A Well Child Check-Up (EPSDT)

The purpose of EPSDT services is:

- To actively seek out all eligible families and educate them on the benefits of preventive health care
- To help recipients effectively use health resources and encourage them to participate in the screening program at regular intervals
- To provide for the detection of any physical and mental problems in children and youth as early as possible through comprehensive medical screenings in accordance with program standards
- To provide for appropriate and timely services to correct or ameliorate any acute or chronic conditions

This appendix offers information about the EPSDT program. It consists of the following sections:

Section	***Contents***
Understanding EPSDT	Provides an overview of EPSDT, including descriptions of screening types and services offered under EPSDT
Performing Screenings	Provides information on becoming an EPSDT screening provider, verifying recipient eligibility, critical components of screenings, and how to submit claims for EPSDT screenings
Providing and Obtaining Referrals	Describes the process for providing referrals to specialists and obtaining referrals from screening providers. This section includes instructions for Patient 1st and non-Patient 1st recipients.
Coordinating Care	Describes the administrative requirements of the EPSDT program, including consent forms and retention of medical records.
Off-site Screenings	Provides an overview of the off-site screening program, including enrollment requirements, components required, eligibility verification, referral process and reimbursement information.
Vaccines for Children	Describes the Vaccines for Children program, including enrollment instructions, which procedure codes to bill, how to bill for administration fees, and a copy of the immunization schedule.

A.1 Understanding EPSDT

The purpose of the EPSDT program is to find children with actual or potential health problems and to screen, diagnose, and treat the problems before they become permanent, lifelong disabilities. The program also offers preventive health services to Medicaid-eligible children under 21 years of age.

The EPSDT program was expanded in the Omnibus Budget Reconciliation Act of 1989 to allow additional services. The acronym EPSDT stands for:

Early	A Medicaid-eligible child should begin to receive high quality preventive health care as early as possible in life.
Periodic	Preventive health care occurring at regular intervals according to an established schedule that meets reasonable standards of medical, vision, hearing, and dental practice established by recognized professional organization.
Screening	A comprehensive, unclothed head-to-toe physical examination to identify those who may need further diagnosis, evaluation, and/or treatment of their physical and mental problems.
Diagnosis	The determination of the nature or cause of physical or mental disease, conditions, or abnormalities identified during a screening.
Treatment	Any type of health care or other measures provided to correct or ameliorate defects, physical and mental illnesses, or chronic conditions identified during a screening.

Periodicity Schedule

Periodic screenings must be performed in accordance with the schedule listed below. This schedule is based upon the recommendations of the American Academy of Pediatrics Guidelines for Health Supervision III.

- 1 month
- 2 months
- 4 months
- 6 months
- 9 months
- 12 months
- 15 months
- 18 months
- 2 years
- Annually through 20 years of age beginning with third birthday

NOTE:

Medicaid will reimburse for only one screening per calendar year for children over the age of three. Screening benefit availability may be verified through AVRS, EDS Provider Electronic Solutions software, or the Provider Assistance Center at EDS. Please refer to Chapter 3, Verifying Recipient Eligibility, for more information.

If a periodic screening has not been performed on time according to the periodicity schedule (for instance, if the 2 months' periodic screening was missed), a screening may be performed at an “in between” age (for example, at 3 months) and billed as a periodic screening. In other words, the child should be brought up to date on his/her screening according to his/her age. Re-screenings should occur within 2 weeks (before or after) of the established periodicity schedule. This policy applies to recipients 0-24 months of age.

EPSDT screenings fall under six broad categories:

Type of Screening	***Description***
Initial Screening	Initial screenings indicate the first time an EPSDT screening is performed on a recipient by an EPSDT screening provider.
Periodic Screening	Periodic screenings are well child checkups performed based on a periodicity schedule. The ages to be screened are 1 month, 2 months, 4 months, 6 months, 9 months, 12 months, 15 months, 18 months, 24 months, and annually beginning on or after the child’s third birthday.
Interperiodic Screening	Interperiodic screenings are considered problem-focused and abnormal. These are performed when medically necessary for undiagnosed conditions outside the established periodicity schedule and can occur at any age.
Vision Screening	Vision screenings must be performed on children from birth through age two by observation (subjective) and history. Objective testing begins at age three, and should be documented in objective measurements.
Hearing Screening	Hearing screenings must be performed on children from birth through age four by observation (subjective) and history. Objective testing begins at age five, and should be recorded in decibels.
Dental Screening	Dental screenings must be performed on children from birth through age two by observation (subjective) and history. Beginning with age three, recipients must be either under the care of a dentist or referred to a dentist for dental care.

A.2 Using PT+3 with EPSDT services

A patient education method (PT+3) has recently been developed for working with illiterate or marginally literate individuals. The PT+3 allows providers to make the most of patient contacts as opportunities to provide developmentally appropriate information for recipients and their families.

The acronym PT+3 means:

P = Personalize the problem

T = "TAKLE" the problem:

- T = set a Therapeutic Tone,
- A = Assess the knowledge level of the patient,
- K = provide Knowledge,
- L = Listen for feedback,
- E = Elaborate or reeducate as needed.

+3 = Summarize the teaching session into three essential points.

PT+3 is a standardized protocol that provides the skills and structure for health care providers to assist young or marginally literate patients in learning and remembering essential points from a health care encounter. PT+3 is designed to increase patient knowledge and compliance. Patients seem to like and understand the simplified information and providers like the process. Using PT+3 saves time for providers and enhances the medical visit for the recipient. PT+3 enables individuals to remember the most important aspects of the medical visit.

Specially designed low literacy materials are available for children (EPSDT Brochures), teens, ("How to Talk to Your Children"), and adults ("Facts about Birth Control") and are free to providers including EPSDT, Patient 1st, and Medicaid family planning providers who receive training in the use of the PT+3 method of education. For more information regarding PT+3, please fax your request to (334) 353-5203, attention "Outreach & Education." Please include your name and telephone number.

A.3 Performing Screenings

This section describes becoming an EPSDT screening provider, verifying recipient eligibility, scheduling screenings, critical components of screenings, and submitting claims for EPSDT screenings.

A.3.1 Becoming an EPSDT Screening Provider

Participation as an EPSDT screening provider is voluntary. To become an EPSDT screening provider, a provider must be an approved Alabama Medicaid provider and must have a 10-digit NPI. New providers should refer to Chapter 2, Becoming a Medicaid Provider, for instructions on receiving an application.

Current Medicaid providers who wish to become an EPSDT screening provider should contact the EDS Provider Enrollment Unit at the following address to obtain EPSDT screening provider enrollment forms, or you may download the information from Internet:

EDS Provider Enrollment
P.O. Box 241685
Montgomery, Alabama 36124-1685
1 (888) 223-3630
Internet:

Provider Types Eligible for Participation

Only certain Alabama Medicaid provider types may become approved EPSDT screening providers. In some cases, these providers are restricted to where they can perform screenings:

This Provider Type	*May Perform Screenings at the Following Locations:*
Physicians	Anywhere a physician is authorized to practice
Nurse practitioners	At a physician's office, Rural Health Clinic, Federally Qualified Health Care Clinic (FQHC), health department, or hospital
Registered Nurses	At a rural health clinic, Federally Qualified Health Care Clinic (FQHC), health department, or hospital **NOTE:** Two-year degree RNs who wish to perform EPSDT screenings must first complete a Medicaid-approved pediatric health assessment course (PAC) or show proof of completion of a similar program of study. BSN's are exempt from taking a PAC.
Physician Assistants	At a physician's office, rural health clinic, Federally Qualified Health Care Clinic (FQHC), health department, or hospital

Providers are not limited to those who are qualified to provide the full range of medical, vision, hearing, and dental screening services. Although a qualified provider may be enrolled to furnish one or more types of screening services, the Alabama Medicaid Agency encourages qualified providers to provide the full range of medical, vision, hearing, and dental screening services to avoid fragmentation and duplication of services.

NOTE:

Medical screenings, including the physical, must be performed by a physician, certified nurse practitioner, registered nurse, or physician's assistant, who is approved to perform well child check-ups. Other trained personnel may perform some screening components (for instance, measurements or finger sticks).

Potential EPSDT off-site providers must submit specific documents (see Section A.6) and be approved to participate as an off-site provider.

A.3.2 Verifying Recipient Eligibility

Reimbursement will be made only for eligible Medicaid recipients. Eligibility and benefit limits should be verified **prior to rendering** services to **ANY** Medicaid recipient.

NOTE:

Every effort should be made to assure that medical, vision, and hearing screenings, including immunizations, are accomplished in one visit, and that fragmentation or duplication of screening services is prevented. Section A.7, Vaccines for Children, describes the immunization schedule.

Recipient eligibility should be verified before providing services for several reasons:

- It will inform you of recipient eligibility
- You will be informed if the recipient is assigned to a managed care provider and who the managed care provider is and his/her telephone number
- You may inquire further to determine how many screenings have been performed to determine benefit availability
- It will provide you with the 13th digit of the recipient's Medicaid number for claim filing purposes

Refer to Chapter 3, Verifying Recipient Eligibility, for the various options available and for general benefit information and limitations.

A.3.3 Outreach

Outreach activities are critical to successful health screening services. The outreach process assures that eligible families are contacted, informed, and assisted in securing health-screening services.

The Alabama Medicaid Agency, in conjunction with the Department of Human Resources, informs the applicant of EPSDT services. For those recipients who do not participate in Patient 1st, a list of current EPSDT screening providers are made available for selection by the recipient. SSI (Category 4) eligible recipients are informed of EPSDT services. Until a child is assigned to a managed care provider (usually notified by mail), the Medicaid-eligible child is permitted to see any Alabama Medicaid provider for EPSDT services without a referral from a managed care provider (i.e., Patient 1st provider).

Once the child has been assigned to a managed care provider, all subsequent visits to other providers must have a prior approved written referral (Form 362) from the managed care provider. However, the following recipients are exempt from the managed care program:

- Foster children
- Dual eligibles (Medicare & Medicaid)
- SOBRA-eligible adults
- Those in institutions and/or group homes
- Recipients in the Lock-in program (restricted to one physician and one pharmacy).

For more information regarding managed care systems, refer to Chapter 39, Patient 1st of this manual or call the Provider Assistance Center at (800) 688-7989.

The Alabama Medicaid Agency's goal is to provide effective outreach services for Medicaid-eligible recipients. EPSDT outreach efforts are aimed at two groups: (a) new Medicaid recipients and (b) all Medicaid-eligible recipients under 21 years of age who have not had a well child screening in the last 12 months. These recipients are notified annually. The recipient is informed about EPSDT services through an outreach letter and is encouraged to make an appointment for an EPSDT screening. Once the recipient is assigned a managed care provider, it is the managed care provider's responsibility to ensure screenings (well child checkups) are performed on time. For those recipients who do not participate in a managed care system, the EPSDT screening provider is responsible for ensuring the screenings are performed on time.

A.3.4 EPSDT Care Coordination

Effective March 1, 2004, the Alabama Medicaid Agency initiated an EPSDT care coordination service available for private and public providers. The goal for EPSDT Care Coordination Services is to provide children with opportunities to maximize their health and development by ensuring the availability and accessibility of comprehensive and continuous preventive health services throughout childhood.

The EPSDT Care Coordination services are available to any provider, at no cost, who wishes to utilize these services. The Agency, along with the Department of Public Health, has identified children at greatest risk and with the potential for effective intervention. These Medicaid eligible recipients will be targeted for outreach.

The scope of services include and are designed to support and assist your office personnel with identifying, contacting, coordinating, and providing follow up for visits with your office for children who are behind on their EPSDT screenings, immunizations, vision/hearing screenings, dental screenings, identify recipients who have high utilization of emergency room visits; follow up services for newborn hearing screenings, elevated blood lead levels, abnormal sickle cell and metabolic results; follow up on referrals, missed appointments, identify children at greatest risk for targeted outreach, and coordination for teen pregnancy prevention services. In addition, Care Coordinators are available to assist with transportation services using Alabama Medicaid's Non-Emergency Transportation (NET) program. Care Coordinators may receive referrals from physicians and dentists regarding medically-at-risk clients who need assistance with keeping appointments and obtaining follow-up care. Lastly, EPSDT Care Coordinators will encourage and assist in recruiting private physicians to improve services to this population.

Participation of qualified EPSDT Care Coordination services is available to the state of Alabama's designated Title V agency, Alabama Department of Public Health. Public Health's primary role is that of care coordinator. Public Health will provide clinical EPSDT services only where those services are not available through the private sector. Public Health will identify health problems. Active physician involvement for treatment is vital. EPSDT Care Coordination services are available by contacting your local county health department. Please visit our website at www.medicaid.alabama.gov and select "General", then select "About". A list of EPSDT Care Coordinators by county and telephone numbers is available to support your office personnel.

A.3.5 Scheduling Screenings

The Alabama Medicaid Agency requires that persons requesting screening services receive the services within 120-180 days from the date the request was made. These persons should be given priority by the screening agency when scheduling appointments.

EPSDT selected providers and Primary Medical Providers (PMP) receive a periodic re-screen list each month. The provider should utilize the periodic re-screen list to notify the EPSDT-eligible recipient when the medical screening is due. An appointment should be made for the next screening on the periodicity schedule. These functions are an integral part of the full screening provider's responsibility and are essential for care coordination. Providers have a total of 120 days from due date or award date (listed on printout) to accomplish screening, necessary referral, and treatment for the recipients listed on the printout.

EPSDT-eligible Medicaid beneficiaries who request well child checkups must be provided regularly scheduled examinations and assessments at the intervals established by Medicaid policy.

Scheduling of initial and periodic screenings is the responsibility of the screening provider. Managed care providers are responsible for overall care coordination for medical, vision, hearing, and dental screenings for recipients who participate in a managed care program. The EPSDT screening provider is responsible for overall care coordination as listed above for those recipients who do not participate in a managed care system.

The EPSDT screening provider should not perform a screening if written verification exists or if notified by another provider that the child has received the most recent age appropriate screening. Also, the EPSDT screening provider should receive prior approval from the managed care provider (if applicable). An additional interperiodic screening may be performed if requested by the parent or if medically necessary.

Please refer to Section A.5, Care Coordination, for more information on screening provider responsibilities.

A.3.6 Critical Components of Screenings

This section describes critical components of periodic, interperiodic, and vision/hearing/dental screenings. It also describes recommended health education counseling topics by age group.

Periodic Screenings

Component	***Description***
Unclothed physical exam	This is a comprehensive head-to-toe assessment that must be completed at each screening visit and include at least the following: • Temperature, and height/weight ratio • Head circumference through age two • Blood pressure and pulse at age three and above • Measure body-mass index when clinically indicated Body-mass index (BMI) – BMI should be performed at each visit if clinically indicated. BMI-for-age charts are recommended to assess weight in relation to stature for children ages 2 to 20 years. The weight-for-stature charts are available as an alternative to accommodate children ages 2-5 years who are not evaluated beyond the preschool years. However, all health care providers should consider using the BMI-for-age charts to be consistent with current recommendations. The charts are available on the American Academy of Pediatrics website at http://www.aap.org .
Comprehensive family/medical history	This information must be obtained at the initial screening visit from the parent(s), guardian, or responsible adult who is familiar with the child's history. The history must include an assessment of both physical and mental health development and the history must be updated at each subsequent visit.
Immunization status	Immunizations and applicable records must be updated according to the current immunization schedule of the Advisory committee on Immunization Practices (ACIP). Dates and providers must be recorded in the medical record indicating when and who gave the vaccines, if not given by the screening provider. The state law has been changed so that private and public healthcare providers may share immunization data. Medicaid recipients shall be deemed to have given their consent to the release by the state Medicaid Agency of information to the State Board of Health or any other health care provider, by virtue immunization data should be recorded in the medical record.

Component	*Description*
TB skin test	Children who should be considered for tuberculin skin testing at ages 4-6 and 11-16 years Children whose parents immigrated (with unknown TST status) from regions of the world with high prevalence of tuberculosis; continued potential exposure by travel to the endemic areas and/or household contact with persons from the endemic areas (with unknown TST status) should be an indication for a repeat TST Children without specific risk factors who reside in high-prevalence areas; in general, a high-risk neighborhood or community does not mean an entire city is at high risk; rates in any area of the city may vary by neighborhood or even from block to block; physicians should be aware of these patterns in determining the likelihood of exposure; public health officials or local tuberculosis experts should help physicians identify areas with appreciable tuberculosis rates Children at increased risk for progression of infection to disease: Those with other medical conditions including diabetes mellitus, chronic renal failure, malnutrition and congenital or acquired immunodeficiencies deserve special consideration. Without recent exposure, these persons are not at increased risk of acquiring tuberculosis infection. Underlying immune deficiencies associated with these conditions theoretically enhance the possibility for progression to severe disease. Initial histories of potential exposure to tuberculosis should be included for all of these patients. If these histories or local epidemiologic factors suggest a possibility of exposure, immediate and periodic TST should be considered. An initial TST should be performed before initiation of immunosupressive therapy for any child with an underlying condition that necessitates immunosupressive therapy. Bacille Calmette-Guérin (BCG) immunization is not a contraindication to TST. HIV indicates human immunodeficiency virus. Initial TST initiated at the time of diagnosis or circumstance, beginning at 3 months of age.* Table 2. Definitions of Positive Tuberculin Skin Test (TST) Results in Infants, Children, and Adolescents* TST should be read at 48 - 72 hours after placement **Induration >5mm** Children in close contact with known or suspected infectious cases of tuberculosis disease: Households with active or previously active cases if treatment cannot be verified as adequate before exposure, treatment was initiated after the child's contact, or reactivation of latent tuberculosis infection is suspected Children suspected to have tuberculosis disease: Chest radiograph consistent with active or previously active tuberculosis Clinical evidence of tuberculosis disease ‡ Children receiving immunosuppressive therapy ‡ or with immunosuppressive conditions, including HIV infection

Component	*Description*
TB skin test (cont.)	**Reaction ≥15mm** Children 4 years of age or older without any risk factors *These definitions apply regardless of previous Bacille Calmette-Guérin (BCG) immunization: erythema at TST site does not indicate a positive test. HIV indicates human immunodeficiency virus. + Evidence by physical examination or laboratory assessment that would include tuberculosis in the working differential diagnosis (e.g. Meningitis). ‡ Including immunosuppressive doses of corticosteroids
Developmental surveillance and assessment	A comprehensive developmental history is required, if appropriate, to determine the existence of motor, speech, language, and physical problems or to detect the presence of any developmental lags. An age-appropriate developmental assessment is required at each screening. Information must be acquired on the child's usual functioning as reported by the child's parent, teacher, health care professional, or other knowledgeable individual. **Developmental assessments must be performed by a RN, BSN; CRNP, PA, or M.D.**
Objective Developmental Screenings	SEE BELOW
Nutritional status screening	Nutritional status must be assessed at each screening visit. Screenings are based on dietary history, physical observation, height, weight, head circumference (ages two and under), hemoglobin/hematocrit, and any other laboratory determinations carried out in the screening process. A plotted height/weight graph chart is acceptable when performed in conjunction with a hemoglobin or hematocrit if the recipient falls between the 10th and 95th percentile.
Health education including anticipatory guidance	Health education and counseling for parent(s) or guardian and the youth (if age appropriate) are required at each screening visit. Health education is designed to assist the parent in understanding what to expect in terms of development. Health education also provides information about the benefits of healthy lifestyles and practices, as well as accident and disease prevention. Providers may use the PT+3 teaching method for anticipatory guidance counseling. PT+3 should be documented in the medical record (i.e., progress notes) listing the three points emphasized.

Objective Developmental Screenings

EPSDT providers are allowed to bill for an objective developmental screening in addition to an EPSDT screening at the 9 month, 18 month, 24 month and 48 month well-child visit. EPSDT providers also have the option of providing the developmental screening anytime that surveillance (medical history of developmental risk factors, parental/caregiver concern) identifies a need. Providers are encouraged to use standardized screening tools that have a moderate to high sensitivity, specificity and validity level and is culturally sensitive. The following code, which is limited to two (2) units per date of service (two different screening tools used), may be used to bill for this screening:

96110 - Developmental testing; limited (eg. Developmental Screening Test II, Early Language Milestone Screen), with interpretation and report.

In order to bill this code, providers must use a standardized screening tool. Examples of screening tools allowed for this code include, but are not limited to:

- Ages and Stages Questionnaire (ASQ)
- Ages and Stages Questionnaire/Social Emotional (ASQ-SE)
- Denver DST/Denver II
- Battelle Developmental Screener
- Bayley Infant Neurodevelopment Screener (BINS)
- Parents Evaluation of Development (PEDS)
- Early Language Accomplishment Profile (ELAP)
- Brigance Screens II
- Modified Checklist for Autism in Toddlers (M-CHAT)
- Vanderbilt Rating Scales
- Behavior Assessment Scale for Children-Second Edition (BASC-II)

Providers must document the screening tool utilized, with interpretation and report, in the child's medical record.

Vision Testing/Screenings

Vision screenings are available either as a result of the EPSDT referral or as a result of a request/need by the recipient. A subjective screening for visual problems must be performed on children from birth through age two by history and observation. Gross examinations should be documented as grossly normal or abnormal. Objective testing begins at age three. Visual acuity screening must be performed through the use of the Snellen test, Allen Cards, photo refraction, or their equivalent. Objective testing must be referred out if not performed by the screening provider.

If a child is uncooperative, perform a subjective assessment. The reason(s) for not being able to perform the test must be documented in the medical record. Proceed with billing the vision screening on the same date of service as the initial or periodic screening. The child should be rescheduled for an appointment to complete the vision screening. Be sure to complete the vision screening within 30-45 days from the original screening date.

If a suspected visual problem manifests itself, regardless of whether such services coincide with the periodicity schedule, an interperiodic screening should be scheduled with the child's physician so the history and problem-focused physical exam, can be obtained and an EPSDT referral issued to the appropriate specialist or consultant.

Providers **must** use an "EP" modifier to designate all services related to EPSDT well-child check-ups, including routine vision and hearing screenings. Post payment reviews are performed to determine appropriate utilization of services.

Trained office staff may perform a vision screening if successfully trained. A staff member must meet the following criteria to be considered trained.

- Employee observes a vision screening being performed on a minimum of three patients by a skilled/trained employee
- Employee verbalizes an understanding of the steps required to perform a vision screening
- Employee performs a vision screening under supervision on a minimum of three patients successfully.

Hearing Testing/Screenings

Hearing screenings are available either as a result of an EPSDT referral or as a result of a request/need by the recipient. A subjective screening for hearing problems must be performed on children from birth through age four by history and observation. Gross examination should be documented as grossly normal or abnormal. Objective testing begins at age five. Hearing screenings must be performed through the use of a pure tone audiometer at 500 and 4,000 Hz at 25 decibels for both ears. If a child fails to respond at either frequency in either ear, a complete audiogram must be done. Objective testing must be referred out if not performed by the screening provider.

If a child is uncooperative, do a subjective assessment. The reason(s) for not being able to complete the test must be documented in the medical record. Proceed with billing the hearing screening on the same date of service as the initial or periodic screening. The child should be rescheduled for an appointment to complete the hearing screening. Be sure to complete the hearing screening within 30-45 days from the original screening date.

If a suspected hearing problem manifests itself, regardless of whether such services coincide with the periodicity schedule, an interperiodic screening should be scheduled with the child's physician so the history and problem-focused physical exam, can be obtained and an EPSDT referral issued to the appropriate specialist or consultant.

Trained office staff may perform a hearing screening if successfully trained. A staff member must meet the following criteria to be considered trained.

- Employee observes a hearing screening being performed on a minimum of three patients by a skilled/trained employee
- Employee verbalizes an understanding of the steps required to perform a hearing screening
- Employee performs a hearing screening under supervision on a minimum of three patients successfully.

Providers **must** use an "EP" modifier to designate all services related to EPSDT well-child check-ups, including routine vision and hearing screenings. Post payment reviews are performed to determine appropriate utilization of services.

Dental Services

Dental care is limited to Medicaid-eligible individuals who are eligible for treatment under the EPSDT Program. Dental screenings must be performed on children from birth through age two by observation/inspection and history. Beginning with age three, recipients must be either under the care of a dentist or referred to a dentist for dental care.

A periodic oral examination is recommended once every six months for eligible Medicaid recipients under 21 years of age. Dental services include emergency, preventive, and therapeutic services as well as orthodontic treatment when medically necessary. A referral, or documentation that recipient is under the care of a dentist is required at age three and older. Follow-up is no longer mandatory. Any time a need for dental care is identified, regardless of the child's age, the child should be referred to a dentist.

Beginning with age one, providers should educate and document that caretakers have been advised of the importance (anticipatory guidance) of good oral healthcare and the need to make a dental appointment. Additional documentation suggestions include providing the caretaker with one of the following phone numbers: dentist, Agency's Dental Program phone number to assist with locating a dentist (334) 242-5997, or the Recipient Inquiry Unit (RIU) number to assist with locating a dentist (800) 362-1504.

Dental care under the Program is available either as a result of the EPSDT referral or as a result of request/need by the recipient. Conditions for each situation are as follows:

1. EPSDT Referral – If the EPSDT Screening Provider determines a recipient requires dental care or if the recipient is three years of age or older and is not currently under the care of a dentist, the recipient must be referred to an enrolled dentist for diagnosis and treatment. After the recipient's dental care is initiated, the consultant's portion of the Referral Form (Form 362) must be completed by the dentist and the appropriate copy must be returned to the screening provider.
2. Recipient Seeking Treatment – If a recipient who has not been screened through the EPSDT Program requires dental care, care may be provided without having a Referral Form. Dental care provided on request of the recipient is considered a partial screening. In this situation, after the required care is completed, the dentist should advise the recipient to seek an EPSDT screening provider to obtain a complete medical assessment.

NOTE:

Dental health care services are available for eligible children under age 21, as part of the EPSDT program. To obtain information about dentists, you may call the Dental Program at (334) 353-5959.

Laboratory Screenings

Laboratory screening procedures must be performed in coordination with other medical screening services at the same visit, whenever possible. If verifiable results are available from another provider that any required laboratory procedure was performed within 30 days prior to the screening visit and there is no indication of a diagnosis that would warrant that the test be redone, it is not necessary to perform the test again. However, the test results or a copy of the test results should be documented in the medical record.

NOTE:

Providers have the option of obtaining the Hgb or Hct and the lead test during the nine month or twelve month well child check-up (EPSDT screening).

The following is a list of tests and procedures of laboratory screenings:

Laboratory Test	***Description***
Metabolic screening	Alabama infants are screened through the Alabama Newborn Screening Program for six metabolic/inheritable disorders (Phenylketonuria, Hypothyroidism, Sickle Cell Disease, Galactosemia, Biotinidase, and Congenital Adrenal Hyperplasia). Effective September 2004, analytes will be tested for the following disorders: maple syrup urine disease, homocystinuria, tyrosinemia, citrullinemia, medium chain acyl-coa dehydrogenase deficiency (MCAD), propionic acidemia, methylmalonic academia, and carnitine transport defect. Testing for detecting disorders in amino acid, fatty acid oxidation and organic acid metabolism will be obtained by using Tandem Mass Spectrometry (MS/MS), and will be added as pilot studies are completed. Additional information on testing disorders may be obtained by accessing the Newborn Screening Program website at: www.adph.org/NEWBORNSCREENING/ . All screening tests are conducted by Alabama Department of Public Health's Bureau of Clinical Laboratories. All newborn testing through the screening program is mandated by **Statutory Authority Code of Alabama 1975, Section 22-20-3**. Every hospital or facility providing delivery services is required to screen all infants for these potentially devastating genetics disorders. A single PKU and T4 is adequate when performed at least 24 hours after birth in a well infant or when performed at 6-7 days of age in a premature or ill infant. Children with no record of the PKU, hypothyroidism, and CAH tests having been performed previously, during one of the neonatal visits, should be tested between birth and six months of age. Children over six months of age who have never been tested need only be screened when ordered by a physician. Routine second testing for galactosemia is not recommended, unless ordered by a physician. Confirmation of positive newborn screening test results is always necessary. Additionally, newborn screening programs should not preclude the pediatrician's assessment of clinical symptoms at any age. Parents of affected children identified through a screening should be routinely offered counseling concerning the occurrence and reoccurrence of the disorder in existing or prospective siblings. These services are available at genetic centers at the University of Alabama in Birmingham and the University of South Alabama in Mobile. It should be noted physicians should not bill for the laboratory tests performed by the Alabama Newborn Screening Program. However, procedure codes 36415 and 36416 with modifier 90 may be billed for the specimen collection when referred to an outside laboratory.

Laboratory Test	***Description***
Sickle Cell Disease and Sickle Cell Trait Screening	State law requires sickle cell screening at birth on all children. An abnormal hemoglobin is performed as part of the Alabama Newborn Screening Program. Please note for recipients less than 6 months of age, sickle cell testing will be reimbursed when performed by electrophoresis. If verifiable results are unobtainable for children from birth to six months of age, a repeat sickle cell test should be performed. Children over age one who have never been tested need only be screened when ordered by a physician. Counseling should be provided, when appropriate, for those with abnormal results. It is recommended that children identified as having sickle cell disease be referred to Comprehensive Sickle Cell Centers at the University of Alabama in Birmingham or the University of South Alabama in Mobile.
Public Health: Alabama Voice Response System (AVRS):	The Alabama Voice Response System (AVRS) is a Newborn Screening Information System, offered by the Alabama Department of Public Health. The AVRS provides 24-hour, seven days a week telephone reporting of screening results in 30 seconds or less directly through a toll free number, (800) 566-1556. The AVRS was designed to allow physicians quick access to Newborn Screening results. The AVRS requires pre-registration with the screening program and positive identification of the caller through two security checks. Physicians are prompted by the system to enter their state license number (preceded by zeros, if needed, to make a seven digit number), in addition to the entry of a four-digit personal identification number or PIN. Physicians may register with the program by completing the **Alabama Voice Response System Registration Form**. This form may be requested by calling the Newborn Screening Program at 334-206-2971 or by accessing the Newborn Screening website at: www.adph.org/NEWBORNSCREENING/ . Applicants will be notified when their form has been processed. Each physician chooses his individual PIN and records the number on the pre-registration form. The PIN must be four numeric characters. Physicians must have available the specimen kit number found on the filter paper collection form preceded by the year of the infant's birth **or** the mother's social security number. Information is provided by recorded voice messages. The infant's name and date of birth are spelled and verified by user response before any test results are given. Along with the test result, information is provided concerning the need for repeat testing or medical follow-up. Additional information may also be obtained by contacting the Newborn Screening Program at (334) 206-2971, (334) 206-5955 or (800) 654-1385.
Iron Deficiency Anemia Screening	Hematocrit or hemoglobin values must be determined at a medical screening visit between 1-9 months of age. However, providers have the option of obtaining the lead and Hct or Hgb at nine or twelve months of age. Hematocrit or hemoglobin must be determined, between 11-20 years of age, and as deemed medically necessary based on physical examination and nutritional assessment.
Urine screening	Urine screening must be performed at the medical screening visit at five years of age and at each visit between 11 and 20 years of age depending on the success in obtaining a voided urine specimen. If specimen is unobtainable, SNA (Specimen Not Available) should be documented. The required screening procedure is a dipstick that shows the measurement of protein and glucose. Urine obtained from recipients between 11 and 20 years of age should be checked for leukocytes. (Effective 10/01/2008 the urinalysis component of an EPSDT screening is no longer a requirement). A urinalysis should only be performed if clinically indicated.

Added: Effective 10/01/2008 the urinalysis…is clinically indicated.

NOTE:

The hgb or hct are included in the screening reimbursement and should not be billed separately.

Deleted: ~~and the urine dipstick for sugar and protein~~

Laboratory Test	*Description*
Lead toxicity screening	All children must have a blood lead toxicity screening at 12 and 24 months of age. Providers have the option of obtaining the lead and Hct or Hgb at 9 or 12 months of age. A lead toxicity screening is also required for any child 36 to 72 months of age who has not previously received a blood lead toxicity screening or who presents with symptoms of possible lead poisoning. All children should receive lead toxicity screenings since all children are vulnerable to blood lead poisoning. Children's blood lead levels increase most rapidly at 9-12 months of age and peak at 18-24 months of age. The screening test of choice is blood lead measurement (replaces the erythrocyte protoporphyrin (EP) test.
Other lab tests	There are several other tests to consider in addition to those listed above. Their appropriateness is determined by an individual's age, sex, health history, clinical symptoms, and exposure to disease. These may include, for example, a pinworm slide, urine culture, VDRL, GC cultures and stool specimen for parasites, ova, and blood. **Note:** The test for VDRL, gonorrhea cultures, intestinal parasites, and pinworms may be done by the Alabama Department of Public Health clinical laboratory, at NO cost to the EPSDT screening provider. The State lab slip must have "EPSDT Program" documented across the top. Other Medicaid approved laboratories may be used to run sickle cell and lead screening tests.

Risk Questionnaire

Providers should assess a child's risk of blood lead poisoning beginning at 9 months of age. Children determined to be at high risk of blood lead poisoning should receive parental education and nutritional counseling. Administering the Risk Assessment Questionnaire instead of a blood lead toxicity screening does not meet Medicaid requirements.

Does child live in or visit a home built before 1950? Yes = High Risk

Does child live in or visit a home built before 1978 under-

going renovation? Yes = High Risk

Does child have a sibling/playmate diagnosed with lead

poisoning? Yes = High Risk

Does child have household members who participate in a lead-

related occupation or hobby? Yes = High Risk

Does child live near lead smelters, battery recycling plants

or other industries likely to release atmospheric lead? Yes = High Risk

Interpretation of Lead Toxicity Screening Results

Interpretation of blood results and follow-up activities based on blood lead concentration are described below and has been adapted from Managing Elevated Blood Lead Levels Among Young Children: Recommendations from the Advisory Committee on Childhood Lead Poisoning Prevention.

Capillary Sample Blood Lead Concentration (μg/dL)	**Comments**
< 10	Is not indicative of lead poisoning.
	Refer to Risk Questionnaire
	If low risk: perform a blood lead toxicity screening at 9-12 months and 24 months of age
	If high risk: Retest in 3 months. If 2nd test <10 μg/dL. Perform a blood lead toxicity screening at 9-12 months and 24 months of age.
10-14	Confirm with venous sample within 3 months
15-19	Confirm with venous sample within 1 month
20-44	Confirm with venous sample within 5 days.
45-59	Confirm with venous sample within 48 hours
60-69	Confirm with venous sample within 24 hours
>70	Confirm with venous sample immediately.

NOTE:

All capillary results that are > 10μg/dL, should be confirmed with a venous blood lead test.

Venous Sample Blood Lead Concentration	***Comments***
<10	Is not indicative of lead poisoning. Refer to Risk Questionnaire: **Low risk:** Perform a blood lead toxicity screening at 9-12 months and 24 months of age. **High risk:** Retest in 3 months. If 2nd test < 10 μg/dL, Perform a blood lead toxicity screening at 9-12 months and 24 months of age.
10-14	Refer for EPSDT care coordination via mailing ADPH-FHS-135, *Elevated Blood Lead Environmental Surveillance Form*, to the address on the bottom of the form within **5 days** of notification of results. Retest within 3 months with venous sample. Schedule retest and provide parental education and nutritional counseling.
15-19	Refer for EPSDT care coordination and environmental investigation via mailing ADPH-FHS-135, *Elevated Blood Lead*

Venous Sample Blood Lead Concentration	***Comments***
	Environmental Surveillance Form, to the address on the bottom of the form within **5 days** of notification of results. Retest within 3 months with venous sample. Schedule retest and provide parental education and nutritional counseling.
20-44	Refer for EPSDT care coordination and environmental investigation via mailing ADPH-FHS-135, *Elevated Blood Lead Environmental Surveillance Form*, to the address on the bottom of the form within **3 days** of notification of results. Retest within 3 months with venous sample or more often as determined by MD. Schedule retests and provide parental education and nutritional counseling.
45-59	Refer for medical treatment (chelation therapy) to MD within **24 hours** if asymptomatic; otherwise, refer for medical treatment immediately. Child should only return to a lead-safe environment after chelation therapy. Refer for EPSDT care coordination and environmental investigation via faxing ADPH-FHS-135, *Elevated Blood Lead Environmental Surveillance Form*, to (334) 206-2983 **immediately** upon notification of results. Retest within **1 month** with venous sample or more often as determined by MD. Schedule retest and provide parental education and nutritional counseling.
60-69	Refer for medical treatment (chelation therapy) to MD within **24 hours** if asymptomatic; otherwise, refer for medical treatment immediately. Child should only return to a lead-safe environment after chelation therapy. Refer for EPSDT care coordination and environmental investigation via faxing ADPH-FHS-135, *Elevated Blood Lead Environmental Surveillance Form*, to (334) 206-2983 **immediately** upon notification of results. Retest within **2 weeks** with venous sample or more often as determined by MD. Schedule retest and provide parental education and nutritional counseling.
>70 µg/dL	Refer for medical treatment (chelation therapy) to MD within **24 hours** if asymptomatic; otherwise, refer for medical treatment immediately. Child should only return to a lead-safe environment after chelation therapy. Refer for EPSDT care coordination and environmental investigation via faxing ADPH-FHS-135, *Elevated Blood Lead Environmental Surveillance Form*, to (334)206-2983 **immediately** upon notification of results. Retest **weekly** with venous sample or more often as determined by MD. Schedule retest and provide parental education and nutritional counseling.

NOTE:

The State Laboratory will supply microvettes, mailing containers and forms for obtaining blood lead levels at no cost to providers upon request. Please contact (334) 260-3400 to obtain additional information.

Public Health Department Services

EPSDT care coordination is initiated for children with a confirmed blood lead level of > 10 μg/dL. EPSDT care coordinators assess the family's social and environmental needs, develop case plan with goal of reducing blood lead levels, educate family regarding lead risk behaviors, schedule blood lead level retest, and refer to appropriate resources regarding lead screening guidelines. An environmental investigation is initiated for children with a confirmed venous blood lead level of ≥ 15 ug/dL. Environmentalists perform an environmental investigation on a residence to identify lead hazards and recommend interim control or abatement measure if necessary.

For clinical consultation contact: Case Management Coordinator, Alabama Childhood Lead Poisoning Prevention Project (334) 206-2933 and/or Pediatric Lead Poisoning Consultant, University of Alabama at Birmingham (800) 292-6678.

Environmental Lead

Environmental Lead Investigations is the investigation of the home or primary residence of an EPSDT-eligible child who has an elevated blood lead level. Please refer to Chapter 101, County Health Departments, for more information.

Normal and Abnormal Diagnoses

An abnormal diagnosis should only be billed when a health problem is identified and is referred for further diagnosis and treatment services. These services may be self-referrals.

A normal diagnosis should be billed when no health problem is identified or when identified health problems are treated immediately (acute or one time problem) during the screening (same day) and no referral is made for further diagnosis and treatment services. A normal diagnosis should also be billed when the only referrals are for *routine* vision, hearing or dental services. Diagnosis codes that may be utilized to indicate a "normal" screening are, but are not limited to: V20.0-V20.2 and V70.0.

Interperiodic Screenings

EPSDT-eligible children may receive medical, vision, hearing, and dental services that are medically necessary to determine the existence of a suspected physical or mental illness or condition, regardless of whether such services coincide with the periodicity schedule for these services. Screenings that are performed more frequently or at different intervals than the established periodicity schedules are called **interperiodic screenings**. An interperiodic screening may be performed before, between, or after a periodic screening if medically necessary. Interperiodic screenings are performed for undiagnosed medically necessary conditions outside the established periodicity schedule. Interperiodic EPSDT screenings are problem-focused and abnormal.

Interperiodic screening examinations may occur even in the case of children whose physical, mental, or developmental illnesses or conditions have already been diagnosed if there are indications that the illness or condition may have become more severe or has changed sufficiently, so that further examination is medically necessary.

By performing an interperiodic screening and issuing and EPSDT referral form, physician office and other benefits will be "saved" for acute illnesses or other sickness. An interperiodic screening should be performed (where a history and problem-focused physical exam occurs) for suspected medical, vision, hearing, psychological, or dental problems in order for an EPSDT referral to be issued for further diagnosis and/or treatment. In this manner, the recipient will be referred for consultation and/or to a specialist for medically necessary and appropriate diagnostic tests and/or treatment. Vision/hearing screenings are to be performed/billed on the same date of service as an initial or periodic screening only. Vision/hearing screenings are limited to one each annually, beginning at age 3 for vision and 5 for hearing. However if a suspected vision/hearing/ dental/medical problem should manifest itself, an interperiodic screening should be performed in order for an EPSDT referral to be issued to a specialist or consultant. For more information regarding vision and hearing screenings, please refer to section A.3.5. For more information regarding dental, please refer to Chapter 13 Dentist. For dental EPSDT referral requirements, please refer to Chapter 13, Section 13.3.3.

An interperiodic screening may be performed based upon a request by the parent(s) or guardian(s), or based on the provider's professional judgment relative to medical necessity. The Alabama Medicaid Agency considers **any** encounter with a health care professional who meets the qualifications for participation in the EPSDT program to be an interperiodic screen, regardless of whether the health care professional is enrolled as a provider with the Agency.

A health developmental or educational professional who comes in contact with the child outside the formal health care system may also determine whether an interperiodic screening is medically necessary. The screening provider must document the person referring the child, and a description of the suspected problem, in the record. See note box for documentation requirements.

Interperiodic screenings must always be filed with the patient's other insurance first. If the primary insurance is a HMO or the provider is a FQHC, IRHC or PBRHC, the interperiodic screening code must be submitted. Once the claim has been paid/denied, Medicaid may then be billed utilizing the interperiodic screening code with an EP modifier appended. When filing for an interperiodic screening, always append an EP modifier or the visit will count against benefit limits.

If the primary insurance is not a HMO, bill the appropriate "office visit" code. Once the claim has been paid/denied from the patient's other insurance, a claim may be filed with Medicaid utilizing the same "office visit" code with an EP modifier appended. When billing an office visit code for an interperiodic code, always append the EP modifier or the visit will count against benefit limits.

NOTE:

If any other treatments are provided the same day (injections, lab, etc.), a "1" or "4" must also be reflected in Block 24h, on each line item, or the claim will deny.

NOTE:

Effective January 1, 2007 and thereafter, interperiodic screening codes have changed. The codes for interperiodic screenings **must be billed with an EP modifier and** are as follows:

99211 EP through 99215 EP for office and/or outpatient interperiodic screenings

99233 EP for Inpatient interperiodic screenings

The new interperiodic screening codes will count against office /hospital visit limits if billed without an EP modifier.

The Evaluation and Management code level of care chosen must be supported by medical record documentation.

Each child's primary insurance must be billed first, and then Medicaid as the payor of last resort.

See page A-24 for a crosswalk of codes used for Interperiodic Screenings.

Intensive Developmental Diagnostic Assessment

An EPSDT Intensive Developmental Diagnostic Assessment is a multidisciplinary comprehensive screening limited to infants' age zero to under two years, and is also limited to two per recipient per lifetime. These screenings are in addition to the routine periodic screenings and must be performed by a qualified EPSDT Intensive Developmental Diagnostic Assessment Screening provider, as approved and enrolled by Medicaid.

NOTE:

Medical necessity is subject to retrospective review by the Alabama Medicaid Agency. Please refer to Chapter 7, Understanding Your Rights and Responsibilities as a Provider, for more information.

Interagency Coordination

The State of Alabama, in conjunction with the Interagency Coordinating Council and the Alabama Department of Rehabilitation Services will implement a system of services to the eligible population (20 USC Section 1471 et seq, Part H), with the assistance of agencies, programs, providers, and the families of eligible infants and toddlers with special needs.

The Alabama Medicaid Agency is one of nine state agencies that hold positions on the Interagency Coordinating Council. The Early Intervention Law legislates a statewide system of early intervention services for eligible infants and toddlers that is comprehensive and coordinated among all disciplines and providers involved, and encourages the development of a system of service delivery that includes parents' participation and input. Services that provide early intervention are to be coordinated across agency and provider lines.

The definition of a child eligible for early intervention includes infants and toddlers under age three inclusive, who are either (1) experiencing developmental delay equal to or greater than 25 percent as measure by appropriate diagnostic instruments and procedures in one or more of the following areas: cognitive development, physical development (including vision and hearing), communication development, social or emotional development, adaptive development; or (2) they have a diagnosed physical or mental condition which has a high probability of resulting n developmental delay are eligible for early intervention services. Early intervention services can include the following:

Audiology	Service coordination
Family training/counseling & home visits	Occupational therapy
Health	Nursing
Medical services for diagnostic/evaluation	Vision services
Nutrition	Physical therapy
Psychological services	Social work
Special instruction	Speech/language pathology
Assistive technology devices & services	Transportation

The Early Intervention Service Coordinator who receives the Child Find referral will contact the EPSDT or Patient 1st provider to obtain the EPSDT screening information and any other pertinent information. In order to coordinate services, once a well child check-up (EPSDT) has been completed and a developmental delay has been indicated, contact Child Find, (**800) 543-3098**. Please refer to the Early Intervention Child Find Referral Form at the end of this Appendix or visit Medicaid's website at: www.medicaid.alabama.gov .

NOTE:

You may refer a family to Alabama's Early Intervention System (AEIS) in addition to referring the child and family to other appropriate services. AEIS staff is located in seven districts in the state. Please call the toll free number if you are interested in information about local EI resources.

Recommended Health Education Counseling Topics

2 weeks-3 months
Nutrition - Spitting up
Hiccoughs
Sneezing, etc.
Safety
Need for affection
Immunizations
Skin and scalp care
Bathing frequency
How to use a thermometer
When to call the doctor

4-6 months
Nutrition
Safety
Teething and drooling/dental hygiene
Fear of strangers
Lead poisoning
Immunizations

7-12 months
Nutrition
Immunizations
Safety
Dental hygiene
Night crying
Separation anxiety
Need for affection
Discipline
Lead poisoning

13-18 months
Nutrition
Safety
Immunizations
Dental hygiene
Temper tantrums
Obedience
Speech development
Lead poisoning

19-24 months
Nutrition
Safety
Need for peer relationship
Sharing
Toilet training
Dental hygiene
Need for attention and patience
Lead poisoning

3-5 years
Nutrition
Safety
Dental hygiene
Assertion of independence
Type of shoes
Need for attention
Manners
Lead poisoning

6-13 years
Nutrition
Safety
Dental care
School readiness
Onset of sexual awareness
Peer relationship (male and female)
Preputertal body changes
Substance abuse
Contraceptive information (if sexually active)

14-21 years
Nutrition
Dental
Safety (automobile)
Understanding body anatomy
Male/female relationships
Contraceptive information
Obedience and discipline
Parent-child relationships
Alcohol, drugs, and smoking
Occupational guidance
Substance abuse

Providers may use the PT+3 teaching method for anticipatory guidance counseling. Providers should document PT+3 counseling was utilized and list the three points emphasized.

Billing Requirements

The table below provides billing information for EPSDT screening claims:

Topic	***Explanation***
Copayment	EPSDT recipients, under 18 years of age, are not subject to co-payments.
Prior Authorization	Screenings are not subject to prior authorization.
Referral	Please refer to Section A.4, Providing and Obtaining Referrals, for more information.
Time Limit for Filing Claims	One year from the date of service
Visit Limitations	An office visit is not billable on the same day with an EPSDT screening by the same provider or provider group.
Diagnosis Codes	The *International Classification of Diseases - 9th Revision - Clinical Modification* (ICD-9-CM) manual lists required diagnosis codes. These manuals may be obtained by contacting the American Medical Association, P.O. Box 10950, Chicago, IL 60610.
Procedure Codes and Modifiers	The following procedure codes should be used when billing comprehensive EPSDT screening services: 99381-99385 with modifier EP Initial EPSDT Screening 99391-99395 with modifier EP Periodic EPSDT Screening 99173 with modifier EP Vision Screening – Annual 92551 with modifier EP Hearing Screening – Annual Effective January 1, 2007 the interperiodic screening codes have changed. The following procedure codes (in service locations other than inpatient hospital) must be used: 99211EP-99215EP You must use an EP modifier in order to bypass office visit benefit limits. For interperiodic screenings performed in an inpatient hospital setting, the following procedure code must be used: 99233EP You must use an EP modifier in order to bypass hospital visit benefit limits. Interperiodic screening codes should have abnormal diagnosis codes. The (837) Professional, Institutional and Dental electronic claims and the paper claim have been modified to accept up to four Procedure Code Modifiers.
Intensive Developmental Diagnostic Assessment	The following procedure codes should be used when billing for an intensive development diagnostic assessment (a multidisciplinary comprehensive screening) for children under two years of age (limited to two per recipient) 96110 - Intensive developmental diagnostic assessment, normal findings 96111 - Intensive developmental diagnostic assessment, abnormal findings
Third Party Coverage	Providers are required to file with available third party resources prior to filing Medicaid. Preventive pediatric services and prenatal care are excluded from this requirement unless the recipient has managed care coverage or Medicaid pays the provider a global fee.
Reimbursement	Governmental screening providers (including physicians) will be paid on a negotiated rate basis, which will not exceed their actual costs. Non-governmental screening providers will be paid their usual and customary charge, which is not to exceed

Topic	*Explanation*
	the maximum allowable rate established by Medicaid.
EPSDT Indicator Reference	The EPSDT Indicator will be either a "Y" or "N", as applicable, when using electronic claims only.

NOTE:

Well child check-up visits (initial, periodic, and interperiodic screenings) do not count against recipient's benefit limits of 14 physician office visits per calendar year. There is no co-pay for recipients under 18 years of age.

A.3.7 Patient 1st, Primary Care Case Management (PCCM) Referral Services

To participate in the PCCM program, physicians are required to:

- Provide an ongoing physician/patient relationship
- Provide primary care services, including prevention, health maintenance and treatment of illness and injury
- Coordinate all patient referrals to specialists and other health services
- Offer 24-hour availability of primary care or referral for other necessary medical services
- Use a preferred drug list
- Follow program procedures
- Participate in the enrollee grievance process
- Meet other minimum program criteria

Physicians who agree to serve as primary medical providers are paid fee components to provide case management services for their patients.

Please refer to the Alabama Medicaid Provider Manual, Chapter 39 for more information regarding the Patient 1st program.

NOTE:

The Patient 1st program does not extend or supersede any existing program benefit or program requirement.

A.3.8 Billing for Patient 1st Referred Services

To bill for a service that requires a Patient 1st referral, the billing provider must have a valid signed referral form in the recipient's medical record. This form should contain the PMP's number to use for billing. If a service does not require a Patient 1st referral it is not necessary to get a referral from the PMP and it is not necessary to retain a referral form in the recipient's medical record. A list of the Patient 1st services "requiring" and "not requiring" a written signed referral are listed in the Alabama Medicaid Provider Manual in Chapter 39.

When billing for referred services the PMP name/10-digit NPI, and indicator "4" must be reflected on either the CMS-1500 (blocks 17, 17a, and 24J) by the specialty physician or on the UB-04 (block 78 and the indicator "A1" in block 24) if a hospital or outpatient clinic is providing the specialty services. If all fields are not properly coded, Medicaid will reject the claim. (Refer to Chapters 5, Filing Claims, and 39, Patient 1st, of the Provider Manual for claim instructions).

If a service performed by the billing provider does not require a Patient 1st referral, do not enter the name of a referring physician and/or the 10-digit NPI on the CMS-1500 (blocks 17 and 17a) or on the UB-04 Claim Form (block 78).

Please refer to Chapter 5, Filing Claims, for information regarding filing claims from a Patient 1st referral.

A.4 Providing and Obtaining Referrals

One of the primary purposes of the EPSDT services is to ensure that health problems are diagnosed and treated early before they become more complex and their treatment more costly. A Medicaid eligible child who has received an EPSDT screening (well child check-up) may receive additional medically necessary health care. These services are considered above the normal benefit limitations and require a referral from an EPSDT screening provider and Patient 1st PMP, if applicable. Some of these referred services require prior authorization from the Alabama Medicaid Agency.

If a child is admitted to the hospital as a result of an EPSDT screening, the days will not count against the yearly benefit limit. Facility fees for outpatient visits will not count against the yearly benefit limit if the visit is the result of an EPSDT screening and referral. Services rendered by speech and occupational therapists are covered **only** as the result of an EPSDT screening.

A.4.1 Vision, Hearing, and Dental Referrals

If the EPSDT screening provider chooses to refer a recipient for vision, hearing, and/or dental services, the recipient must be referred to the appropriate provider for diagnosis and/or treatment. After the recipient's vision, hearing, and/or dental service is initiated, the consultant's portion of the EPSDT referral form must be completed by the consultant and the appropriate copy must be returned to the screening provider. Referral forms should be returned in 30 days, from the date of the appointment, or (if no appointment was made) from the date of the screening examination.

NOTE:

If the recipient is three years of age or older and is not under the care of a dentist, the recipient must be referred to a dentist for diagnosis and/or treatment. Follow-up on dental referrals is not required.

A referral form is completed by the screening provider when an abnormality or condition is noted during the child's screening that requires further diagnosis and/or treatment. The referring provider must document the condition(s) within the medical record (either in the medical history or physical exam portion). Medicaid has the right to recoup the screening service fees from the referring provider when a referral is made for a condition not documented in the medical record (in medical history or physical exam portion).

A.4.2 Referrals Resulting from a Diagnosis

If, as a result of a medical, vision, hearing, or dental screening, it is suspected or confirmed that the child has a physical or mental problem, the screening provider and Patient 1st PMP, if applicable, must refer the child without delay for further evaluation of the child's health status. Follow-up is required to assure that the child receives a complete diagnostic evaluation. Diagnostic services may include but are not limited to physical examination, developmental assessments, psychological and mental health evaluation, laboratory tests and any x-rays. Diagnosis may be provided at the same time or it may be provided at a second appointment.

The time limit for completing the referral form (Form 362) requires the form to be completed within 364 days of the date of the screening. If an abnormality or condition is noted during an EPSDT screening and an EPSDT referral form is not issued at the time (for example, sickle cell remission), an EPDST referral may be issued at a later date for the same diagnosis only (for example, sickle cell remission changes to sickle cell crisis). In this instance, the date utilized on the referral form will be the same as the date of the EPSDT screening where the abnormality/condition was noted. If another abnormality or condition occurs that was not diagnosed during an EPSDT screening, or if a condition has changed sufficiently so that further examination is medically necessary, an interperiodic screening should be performed (or periodic screening if it is due) to identify the problem.

EPSDT referrals are valid for one year from the date of the EPSDT screening. Therefore the maximum time an EPSDT referral is valid is 12 months from the date of the well child check-up (EPSDT screening). The EPSDT screening date must be current to be valid. The EPSDT screening date may not be backdated or future dated. The date of the EPSDT screening should be documented under "Type of Referral" on form 362, the Alabama Medicaid Agency Referral Form. The EPSDT screening date documented on the Referral Form is the date used to determine the length of time an EPSDT referral is valid (regardless of a Patient 1st referral). The "Length of Referral" is used to determine the amount of time the referral is valid from the referral date and is inclusive of all types of referrals (e.g., Patient 1st referral, EPSDT referral, Targeted Case Management, etc). Please refer to Appendix E, Medicaid Forms, for additional information.

Diagnosis and treatment services may be provided by the screening provider (self referral) or may be obtained by referral to any other practitioner or facility qualified to evaluate, diagnose, or treat the child's health problem.

NOTE:

The number of visits or months must be documented on the EPSDT referral form to be considered a valid referral.

A.4.3 Treatment

Treatment may include but is not limited to physicians' or dentists' services, optometrists' services, podiatrists' services, hospital services (inpatient and outpatient), clinic services, laboratory and X-ray services, prescribed drugs, eyeglasses, hearing aids, prostheses, physical therapy, rehabilitation services, psychological services, and other types of health care and mental health services.

If a condition requires a referral, it is the responsibility of the screening provider and Patient 1st PMP, if applicable, to:

- Document the abnormality discovered during the EPSDT screening in the record
- Determine what resources a child needs and to which provider he/she wishes to be referred (the recipient's freedom of choice of providers must be ensured)
- Make the appropriate referral in a timely manner
- Offer and provide assistance in scheduling the appointment
- Verify whether the child received the service. Referrals must be followed up within 30 days (excluding dental) from the date of the appointment with the consultant.

A.4.4 Completing the Referral Form

The Referral for Services Form 362 must be completed after a screening if further diagnosis and/or treatment are required for a child not assigned to a PMP. The referral form is completed when referring the recipient to other providers for services that were identified during the screening as medically necessary.

Refer to Appendix E, Medicaid Forms, for a sample of the Alabama Medicaid Agency Referral Form.

Screening providers must include their 10-digit National Provider Identifier (NPI), name, and address for those recipients who do not participate in managed care (i.e., Patient 1st).

PMPs must include their 10-digit National Provider Identifier (NPI), name, and address for those recipients who participate in Patient 1st.

- The **screening provider** must document the time span in which the referral is valid. The maximum time span is 12 months from the date of the screening.

- The **consulting provider** must follow the appropriate billing instructions and guidelines for completion of the CMS 1500 claim form found in Chapter 5, Section 5.2.2 of the Alabama Medicaid Provider Manual.

NOTE:

Once benefit limitations have been exceeded, Medicaid will not pay for services without the EPSDT referral. This is important for patients with chronic conditions or a problem that will require numerous visits to treat. Providers should write the referral as soon as the condition is noted so that the regular benefits are not exhausted.

The referral form should follow the recipient for all services related to the condition noted on the form. If a child is screened with a particular condition noted and referred for further diagnosis, and another condition develops that is not noted on the referral form, the child must be re-screened in order to receive expanded benefits for the second condition noted. If not re-screened, the services rendered would count against the child's routine benefit limits.

NOTE:

If the screening provider refers a child to a consultant, it is the screening provider's responsibility to follow up. However, if the managed care provider refers the child to a consultant, it is the managed care provider's responsibility to follow up.

A.4.5 EPSDT Referrals for Patient 1st Recipients

Scenario: A child is referred by the PMP to be screened by a county health department and appears to have a foot deformity.

Procedure: The child **must** be sent to their assigned Primary Medical Provider (PMP) to obtain the PMP referral form. The PMP may choose to

- Provide the necessary treatment
- Refer the child to an orthopedic specialist
- Instruct the screening provider to complete the referral form

The PMP must complete the Alabama Medicaid Agency Referral Form (Form 362) if referring the child to a specialist. The name and address of the screening provider should be entered to reflect, in this scenario, the county health department. The screening NPI and signature will reflect the county health department number and the signature of the health department employee who performed the screening.

The referring/PMP number reflects the NPI of the PMP. The consulting provider must use the PMP's number as the referring physician on the claim form.

In this scenario, the specialist may suggest surgery, braces, and/or therapy. All services approved by and referred by the PMP would then be covered by an EPSDT screening referral.

NOTE:
The PMP must be contacted and approve any and all referrals made by the specialist.

A.4.6 EPSDT Referrals for Non-Patient 1st Recipients

Scenario: A child is screened by a county health department and appears to have a foot deformity.

Procedure: This child is referred to a pediatrician. The pediatrician may then refer the child to an orthopedic specialist. The specialist may suggest surgery, braces, and/or therapy.

All services in this scenario are covered by the original EPSDT screening referral, which must follow the child from visit to visit. Each provider treating the condition diagnosed during the screening, and documented in the referral, must include the referring provider's number on the claim form. Please refer to Chapter 5, Filing Claims, for instructions on including the referring NPI on the claim form.

A.4.7 Billing Instructions for Referred Services

For EPSDT Referred Services

If you file hard copy claims on the **UB-04**, you must complete the following fields:

- Block 2 – Enter the screening provider's 10-digit National Provider Identifier (NPI)
- Block 24 – Enter "**A1**" to indicate EPSDT

If you file **electronically** on the UB-04 (837 Institutional) using EDS *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you file claims on the **CMS-1500**, you must complete:

- Block 17 – Enter the name of screening provider
- Block 17a – Enter the screening provider's 10-digit National Provider Identifier (NPI)
- Block 24H – Enter "**1**" to indicate EPSDT

If you file **electronically** on the CMS-1500 (837 Professional) using EDS *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

For Patient 1st and EPSDT Referred Services

If you file claims on the **UB-04**, you must complete:

- Block 2 – Enter the referring PMP's 10-digit National Provider Identifier (NPI)
- Block 24 – Enter "**A1**" to indicate EPSDT and managed care

If you file electronically on the UB-04 (837 Institutional) using EDS *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

If you file claims on the **CMS-1500**, you must complete:

- Block 17 – Enter the name of referring PMP
- Block 17a – Enter the referring PMP's 10-digit National Provider Identifier (NPI)
- Block 24H – Enter "**4**" to indicate EPSDT and managed care

If you file **electronically** on the CMS-1500 (837 Professional) using EDS *Provider Electronic Solutions* software, please refer to the latest edition of the Provider Electronic Solutions User Manual.

NOTE:

Each line item on the CMS-1500 Claim Form must have an indicator in Block 24 or 24H if billing for a Referred Service.

For Example: If the first line is an office visit and the indicator in Block 24 Or 24H is a "4" , All additional services for that Date Of Service must also have an indicator of "4" in Block 24 Or 24H or the claim will deny.

Coordinating Care

The Alabama Medicaid Agency establishes the service standards and requirements that the providers must meet.

Providers of medical screening services are responsible for overall care coordination for those recipients that are not enrolled in a managed care system. For those recipients who are enrolled in a Managed Care system, it is the managed care provider's responsibility for overall care coordination. These ongoing activities include scheduling, coordinating, follow-up, and monitoring necessary EPSDT screening and other health services.

Care coordination enhances EPSDT Program efficiency and effectiveness by assuring that needed services are provided in a timely and efficient manner and that duplicated and unnecessary services are avoided.

A.4.8 Consent Forms

Since EPSDT screenings are voluntary services, some parents of children may decline a screening. This does not preclude the child from receiving a screening at a later date or receiving medically necessary diagnosis, treatment or other health services separate from the screening, providing such services do not exceed normal benefit limitations.

A "Consent for Services" form must be signed at each visit by the responsible adult. The consent could be a permission form to treat or a signature reflecting the date the service is rendered (e.g., a sign-in sheet). The consent for services should be filed in the patient's permanent medical record. If a sign-in logbook is used, the provider will need to keep this record for a minimum of three years plus the current year. The responsible adult must be present at the time of the screening to give pertinent history and developmental status and to receive counseling as indicated. The absence of a responsible adult as defined above would invalidate the screening. When off-site screenings are performed, the parent may complete the history form prior to the screening in compliance with Off-Site Screening Protocol. Recipients 14 years of age or older may sign for themselves.

A.4.9 Medical Records

All screening providers must maintain complete records for three years plus the current year on all children who have received services or screened. Records of all EPSDT-eligible children must be made available to Medicaid upon request. Medicaid will monitor EPSDT services provided by screening physicians or agencies on a periodic basis. If Medicaid identifies claims paid where any three findings listed as critical components of the screening process are omitted, the claim may be adjusted.

Medical records must include the following documentation. The critical components of a well child check-up (comprehensive screening) are denoted with an asterisk.

- Consent signature
- * Family history of diseases and annual updates
- * Medical history and updates at each screening
- Mental health assessment
- * History of immunizations and administration as indicated
- * Age-appropriate developmental assessment
- * Age-appropriate anticipatory guidance
- * Nutritional assessment to include recorded results of hemoglobin/hematocrit and plotted height/weight
- * Documentation of sickle cell test results
- * Recorded results of hemoglobin/hematocrit

Added: (Effective 10/01/2008, urine…if clinically indicated)

- *urine test for protein and sugar (Effective 10/01/2008, urine screening needs to be performed only if clinically indicated)
- * Lead testing/results (according to age)
- Tb skin test
- Height, weight, temperature, pulse, and blood pressure
- * Vision and hearing assessment/testing (Considered as two critical components)
- * Documentation of the unclothed physical examination
- * Dental referral/status for recipients 1 year of age and above
- * Failure to make appropriate referral, when required (i.e., medical, vision, hearing)

- * Referral follow-up on conditions related to medical, vision, or hearing problems

A.5 Off-site Screenings

Children are our state's most important assets and yet many of them arrive at school generally in poor health. The healthier a child, the greater his or her learning potential. The Alabama Medicaid Agency is committed to helping ensure that children are healthy and ready to learn. To that end, the Alabama Medicaid Agency has developed protocols for off-site EPSDT screenings. These services must be accessible to all children, not just Medicaid-eligible children.

NOTE:

EPSDT screening providers must also contact the recipient's primary medical provider (Patient 1st) to receive prior authorizations to perform the screening.

Off-site screenings are defined as screenings that are provided off-site from a medical facility, which is limited to hospitals, physician offices, Department of Public Health (DPH) clinics, and Federal/State certified clinics. Off-site screenings occur in schools, day care centers, head start centers, and housing projects.

An off-site EPSDT screening provider must develop and adhere to confidentiality policies set out by the respective agencies and should be submitted to the agency. Information pertinent to the child's performance may be shared. Information pertinent to infectious disease shall be released only by the County Health Officer. Sharing information with others outside the local agency may take place only if parental consent has been given.

Provider is defined as and will include only a county health department clinic, hospital, FQHC, IRHC, PBRHC, or a physician's office. A provider must be located within the county or within 15 miles of the county in which the off-site screenings occur. Medical personnel performing the physical examination are limited to physicians, certified registered nurse practitioners (CRNP), certified nurse midwives (CNM), physician assistants (PA), and registered nurses (RN) employed by the facilities listed above.

Clinic is defined as a certified medical facility, under the supervision of a physician that provides a full range of medical services on a regular basis. A clinic must be equipped to handle acute care situations and provide treatment and/or management of chronic diseases. Licensed medical personnel must perform medical services.

Medical facility is defined as a Federal/State certified clinic, hospital, physician's office, or a DPH clinic where diagnosis of health problems are rendered and treatment of diseases occur. The medical facility must have a permanent location, regularly scheduled hours of operation, and a published telephone number. Medical services and supplies must also be available for treatment of abnormal conditions identified at the time of an EPSDT screening.

Physician's office is defined as a place staffed by physician(s) and other medical professionals where medical activities, such as the practice of medicine, is conducted. This office is specifically designed and set up to provide medical diagnosis and treatment of medical conditions. This office is open and operating on a published, regularly scheduled basis with a published telephone number and regularly scheduled appointments.

A.5.1 Enrollment for Off-site providers

To be considered as an EPSDT screening provider for off-site screenings, potential providers must submit the following criteria:

- A letter documenting the ability to complete all components of a screening. The physical exam portion of the screening must be completed by an approved EPSDT screening provider: physician, nurse practitioner, physician assistant, or a registered nurse. All registered nurses, except BSNs, must complete a Medicaid-approved Pediatric Assessment course or show proof of having completed a similar program of study in their professional training that prepared them to perform pediatric health assessments.

- A primary care referral list of medical providers in the county to whom you will refer to services. The referral list must include pediatricians, family and/or general practice physicians, internal medicine physicians, vision and hearing providers, and dentists. All providers must agree to be on your referral list, therefore, you must submit their written agreement with your referral list. The list must be sufficient in number to allow recipients/parents a choice in the selection of a provider.

- Documentation to demonstrate that services will be offered to all children enrolled at an off-site location, not just Medicaid-eligible children. A copy of your fee schedule must be attached to your documentation and must include fees for non-Medicaid enrollees.

- Child abuse and confidentiality policies

- A signed Matrix of Responsibilities form between the off-site location authority (school superintendent, principal, day care director, etc.) and the screening provider. Only one screening provider will be approved per location.

NOTE:

Only RNs that are employed by a FQHC, RHC, Health Department, Physicians office, and hospital may perform off-site EPSDT screenings.

- A signed agreement/letter from a local physician to serve as Medical Director. This physician may be a pediatrician, family practice physician, general practice physician, or an internal medicine physician. Proof of 6 pediatric focused credits (CME) from the previous year must be included with the signed agreement. EXCEPTION: A board-certified pediatrician should submit a copy of current certification only. **The medical director is responsible for resolving problems that the nurses encounter and rendering care for medical emergencies.**

- A monthly schedule shall be maintained designating the dates, times, and the local agency in which you will be offering the EPSDT services. The monthly schedule should be readily available and retained in either the local agency/medical facility (i.e., the facility that has been approved as an off-site EPSDT screening provider) or the recipient's medical record. Failure to maintain schedules one week in advance of Off-site EPSDT screenings may result in termination and loss of revenue.

- A document, listing members of the Peer Review Coalition of community members to serve in an advisory capacity. The committee must have the opportunity to participate in policy development and program administration of the provider's off-site program and to advise the director about health and medical service needs within the community. The committee must be comprised of parents, school personnel, public health personnel and local physicians within the local community. Members must be familiar with the medical needs of low-income population groups and with the resources available in the community.

- Information packet materials, including letters, forms, and examples of anticipatory guidance information sheets to be used. These materials must be prior approved by Medicaid.

- A copy of the waiver certificate and/or CLIA number, issued by the Division of Health Care Facility, Bureau of Health Provider Standards for the State of Alabama Department of Public Health.

- A list of all physical locations at which EPSDT screenings will be provided. A separate NPI will be assigned to each off-site location and will be distinct from any other NPI. A separate application and contract is required for each off-site location.

A.5.2 Space for Screenings

The room in which screenings are done may vary according to the availability of space. Space to perform the screening assessment must include a well-lighted private room in close proximity to hot and cold running water, a bathroom, and a nearby waiting area.

A.5.3 Parent/Guardian Consent and Follow-up

Children under 14 years of age must have written consent from their parent/guardian before participating in the screening program. Children age 14 and above may consent for themselves. The parent/guardian should be encouraged to be present during the screening.

Once the health screening is complete, the parent/guardian must be informed of the results of the screening by mail or in a one-on-one meeting. The anticipatory guidance materials must be age appropriate and the material may be given to children 14 years of age and above. Documentation must reflect that anticipatory guidance materials were mailed to parent/guardian for recipients under 14 years of age.

NOTE:

The potential provider cannot begin well child check-ups (screenings) until approval has been authorized in writing and Medicaid has enrolled the provider for off-site screenings.

A.6 Vaccines for Children

In an effort to increase the immunization levels of Alabama's children by two years of age, the Alabama Department of Public Health and the Alabama Medicaid Agency implemented the Vaccines for Children (VFC) Program on October 1, 1994,

This nationally sponsored program offers free vaccines to family and general practitioners, pediatricians, hospital nurseries, emergency rooms, and other qualified providers for children aged 18 years and under who are Medicaid enrolled and eligible, have no health insurance, or are American Indian or Alaskan Native. Free vaccines are also available to children who do not have health insurance for immunizations ("underinsured"), if they obtain those vaccines from a Federally Qualified Health Center or Rural Health Clinic.

Participation in Medicaid is not required for VFC enrollment; however, over 400,000 of Alabama's children are Medicaid enrolled.

A.6.1 Fees

Medicaid has taken the past vaccine and administration fee costs and calculated an equivalent reimbursement fee of $8.00 per dose. When multiple doses are given on the same visit, Medicaid will reimburse for each dose. When doses are given in conjunction with an EPSDT screening visit, an administration fee of $8.00 per dose will also be paid. When doses are given in conjunction with an office visit, an administration fee of $8.00 per dose will also be paid.

Providers should use the immunization(s) procedure code designated by the VFC Program when billing for the administration of an immunization. Please refer to section A.6.3 for the list of designated VFC procedure codes.

Medicaid VFC providers may give VFC vaccines to children who are Medicaid enrolled, non-Medicaid, uninsured, American Indian, or Alaskan Native. If a VFC vaccine is given to any of the above patients, with the exception of Medicaid enrolled, an administration fee not to exceed $14.26 for each vaccine administered may be charged. Underinsured patients must go to an FQHC, RHC, or county health department to receive VFC vaccines. An administration fee not to exceed $14.26 for each vaccine administered may be charged. No VFC-eligible patient should be denied immunizations because of an inability to pay the administration fee.

Physicians and health departments are not required to file recipient health insurance prior to filing Medicaid for preventive pediatric services, including administration fees for VFC. Exceptions to this rule require that all providers must file with a recipient's health plan when the plan is an HMO or other managed care plan. In addition, FQHCs and RHCs are required to file other insurance prior to filing Medicaid as are any providers receiving a lump sum payment for bundled services or a capitation payment from Medicaid.

A.6.2 Enrollment

The Department of Public Health is the lead agency in administering the VFC Program. Enrollment and vaccine order forms are available through the Immunization Division. Questions regarding enrollment should be directed to the VFC Coordinator at (800) 469-4599.

Participation in Medicaid is not required for VFC enrollment. Participation in the VFC Program is not required for Medicaid enrollment.

A.6.3 Vaccines for Children Billing Instructions

Providers must use an appropriate CPT-4 code on a CMS-1500 claim form in order to receive reimbursement for the administration of each immunization given from VFC stock.

When immunizations are given in conjunction with an EPSDT screening visit or physician office visit, an administration fee of $8.00 per injection will be paid for recipients 18 years or younger. The statewide fee-for-service rate will be paid for recipients 19 and 20 years old.

NOTE:

A VFC provider may or may not choose to become an enrolled Medicaid provider. Enrollment as a VFC provider or a Medicaid provider is independent of each other.

The following CPT-4 codes must be used when billing Medicaid for immunizations for any recipient under age 21:

CPT-4 Procedure Code	*Immunization*
90633	Hepatitis A, 2-dose pediatric formulation (12months-18years of age) – Eff. 2/1/06
90636	Hepatitis A & B, 3-dose adult formulation (18 years of age only) – Eff. 2/1/06
90645	Hemophilus influenza type b (Hibtiter)
90647	Hemophilus influenza type b (Pedvax)
90648	Hemophilus influenza type b (ActHib)
90649	Human Papilloma Virus (HPV) Vaccine, Types 6,11,16,18 (Quadrivalent), 3-dose schedule-Eff. 11/1/06 (9-18 years)
90655	Influenza, preservative-free (6-35 months) – Eff. 1-1-05
90656	Hemophilus influenza split virus, preservative free (3 years and older)
90657	Influenza (6-35 months)
90658	Influenza (3 years and older)
90660	Influenza Virus Vaccine, Live, For Intranasal Use (LAIV) eff. 10/1/06 (2 years and older)
90669	Pneumococcal Conjugate vaccine 7 valent (Pnu 7)
90680	Rotavirus Vaccine, Pentavalent, 3 dose schedule, live, for oral use (6-32 weeks of age only) eff. 2/3/06
90681	Rotarix is a new Rotavirus vaccine (RV1), and is a two-dose series, for 2 and 4 months of age- Effec. 06/25/2008
90696	Kinrix (DTaP-IPV) is indicated as a booster dose for children 4 through 6 years of age (prior to 7 years of age)- Effec. 06/26/2008
90698	Pentacel (DTaP-Hib-IPV-) is indicated as a primary series and first booster dose (doses 1-4) at 2, 4, 6 and 15-18 months of age – Effec. 06/26/2008

Added: 90681, 90696 and 90698

CPT-4 Procedure Code	*Immunization*
90700	Diphtheria, Tetanus, Acellular Pertussis (DtaP)
90702	Diphtheria, Tetanus (DT)
90707	Measles, Mumps, Rubella (MMR))
90708	Measles and Rubella Virus Vaccine, Live, for subcutaneous use (0-18 years of age)
90710	Measles, Mumps, Rubella, and Varicella (MMRV) vaccine, Live, for subcutaneous use (1-12 years of age) – Eff. 9/6/05
90713	Poliomyelitis (IPV)
90714	Tetanus, Diphtheria (Td), preservative-free – Eff. 7-1-05
90715	Tetanus Toxoid, Reduced Diphtheria Toxoid and Acellular Pertussis Vaccine, Adsorbed (Tdap) – Eff. 5-3-05
90716	Varicella (Chicken pox) vaccine *(for selected recipients)*
90718	Tetanus and Diptheria (Td) (*for adult use*)
90721	Diphtheria, Tetanus, Acellular Pertussis and *Hemophilus influenza type b,(DTaP-HIB) (1-5 yrs. of age)*
90723	Pediarix (DtaP-Hep B-IPV)
90732	Pneumococcal polysaccharide virus 23 valent (Pnu 23)
90733	Meningococcal Polysaccharide (MPSV4), (2-18 yr of age) – Eff. 2-10-05
90734	Memingococcal Conjugate (MCV4), (11-18 yr of age) – Eff 3-1-05
90744	Hepatitis B vaccine (Hep B)
90748	Hepatitis B and *Hemophilus influenza b* (Hep B-Hib) (0-18 yrs of age)

A.6.4 ImmPRINT Immunization Provider Registry

The Alabama Department of Public Health has established a statewide immunization registry. Please visit their website at https://siis.state.al.us/ for more information.

A.6.5 Recommended Immunization Schedule

The chart on the next page provides the recommended immunization schedule or you may access the schedule at www.cdc.gov/nip.

The schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines. Combination vaccines may be used whenever any components of the combination are indicated and its other components are not contraindicated. Providers should consult the manufacturers' package inserts for detailed recommendations.

A.6.6 Synagis

The drug Synagis must be prior authorized through Health Information Designs (HID) at 1-800-748-0130. The new form for prior authorization is available on our website at www.mediaid.alabama.gov under Programs: Pharmacy: Prior Authorizations/Override Criteria and Forms: Instruction Booklet for Form 369 and Form 351. The appropriate administration fee may be billed in addition to Synagis.

Recommended Immunization Schedule for Persons Aged 0–6 Years—UNITED STATES • 2008

For those who fall behind or start late, see the catch-up schedule

Vaccine ▼ Age ▶	Birth	1 month	2 months	4 months	6 months	12 months	15 months	18 months	19–23 months	2–3 years	4–6 years
Hepatitis B[1]	HepB	HepB		see footnote 1	HepB						
Rotavirus[2]			Rota	Rota	Rota						
Diphtheria, Tetanus, Pertussis[3]			DTaP	DTaP	DTaP	see footnote 3	DTaP				DTaP
Haemophilus influenzae type b[4]			Hib	Hib	*Hib*[4]	Hib					
Pneumococcal[5]			PCV	PCV	PCV	PCV				PPV	
Inactivated Poliovirus			IPV	IPV	IPV		IPV				IPV
Influenza[6]					Influenza (Yearly)						
Measles, Mumps, Rubella[7]						MMR					MMR
Varicella[8]						Varicella					Varicella
Hepatitis A[9]						HepA (2 doses)				HepA Series	
Meningococcal[10]										MCV4	

Range of recommended ages

Certain high-risk groups

This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2007, for children aged 0 through 6 years. Additional information is available at www.cdc.gov/vaccines/recs/schedules. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations, including for **high-risk conditions**: http://www.cdc.gov/vaccines/pubs/ACIP-list.htm. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at www.vaers.hhs.gov or by telephone, 800-822-7967.

1. Hepatitis B vaccine (HepB). *(Minimum age: birth)*

At birth:

- Administer monovalent HepB to all newborns prior to hospital discharge.
- If mother is hepatitis B surface antigen (HBsAg) positive, administer HepB and 0.5 mL of hepatitis B immune globulin (HBIG) within 12 hours of birth.
- If mother's HBsAg status is unknown, administer HepB within 12 hours of birth. Determine the HBsAg status as soon as possible and if HBsAg positive, administer HBIG (no later than age 1 week).
- If mother is HBsAg negative, the birth dose can be delayed, in rare cases, with a provider's order and a copy of the mother's negative HBsAg laboratory report in the infant's medical record.

After the birth dose:

- The HepB series should be completed with either monovalent HepB or a combination vaccine containing HepB. The second dose should be administered at age 1–2 months. The final dose should be administered no earlier than age 24 weeks. Infants born to HBsAg-positive mothers should be tested for HBsAg and antibody to HBsAg after completion of at least 3 doses of a licensed HepB series, at age 9–18 months (generally at the next well-child visit).

4-month dose:

- It is permissible to administer 4 doses of HepB when combination vaccines are administered after the birth dose. If monovalent HepB is used for doses after the birth dose, a dose at age 4 months is not needed.

2. Rotavirus vaccine (Rota). *(Minimum age: 6 weeks)*

- Administer the first dose at age 6–12 weeks.
- Do not start the series later than age 12 weeks.
- Administer the final dose in the series by age 32 weeks. Do not administer any dose later than age 32 weeks.
- Data on safety and efficacy outside of these age ranges are insufficient.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP). *(Minimum age: 6 weeks)*

- The fourth dose of DTaP may be administered as early as age 12 months, provided 6 months have elapsed since the third dose.
- Administer the final dose in the series at age 4–6 years.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib). *(Minimum age: 6 weeks)*

- If PRP-OMP (PedvaxHIB® or ComVax® [Merck]) is administered at ages 2 and 4 months, a dose at age 6 months is not required.
- TriHIBit® (DTaP/Hib) combination products should not be used for primary immunization but can be used as boosters following any Hib vaccine in children age 12 months or older.

5. Pneumococcal vaccine. *(Minimum age: 6 weeks for pneumococcal conjugate vaccine [PCV]; 2 years for pneumococcal polysaccharide vaccine [PPV])*

- Administer one dose of PCV to all healthy children aged 24–59 months having any incomplete schedule.
- Administer PPV to children aged 2 years and older with underlying medical conditions.

6. Influenza vaccine. *(Minimum age: 6 months for trivalent inactivated influenza vaccine [TIV]; 2 years for live, attenuated influenza vaccine [LAIV])*

- Administer annually to children aged 6–59 months and to all eligible close contacts of children aged 0–59 months.
- Administer annually to children 5 years of age and older with certain risk factors, to other persons (including household members) in close contact with persons in groups at higher risk, and to any child whose parents request vaccination.
- For healthy persons (those who do not have underlying medical conditions that predispose them to influenza complications) ages 2–49 years, either LAIV or TIV may be used.
- Children receiving TIV should receive 0.25 mL if age 6–35 months or 0.5 mL if age 3 years or older.
- Administer 2 doses (separated by 4 weeks or longer) to children younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time last season but only received one dose.

7. Measles, mumps, and rubella vaccine (MMR). *(Minimum age: 12 months)*

- Administer the second dose of MMR at age 4–6 years. MMR may be administered before age 4–6 years, provided 4 weeks or more have elapsed since the first dose.

8. Varicella vaccine. *(Minimum age: 12 months)*

- Administer second dose at age 4–6 years; may be administered 3 months or more after first dose.
- Do not repeat second dose if administered 28 days or more after first dose.

9. Hepatitis A vaccine (HepA). *(Minimum age: 12 months)*

- Administer to all children aged 1 year (i.e., aged 12–23 months). Administer the 2 doses in the series at least 6 months apart.
- Children not fully vaccinated by age 2 years can be vaccinated at subsequent visits.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children.

10. Meningococcal vaccine. *(Minimum age: 2 years for meningococcal conjugate vaccine (MCV4) and for meningococcal polysaccharide vaccine (MPSV4))*

- Administer MCV4 to children aged 2–10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups. MPSV4 is also acceptable.
- Administer MCV4 to persons who received MPSV4 3 or more years previously and remain at increased risk for meningococcal disease.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

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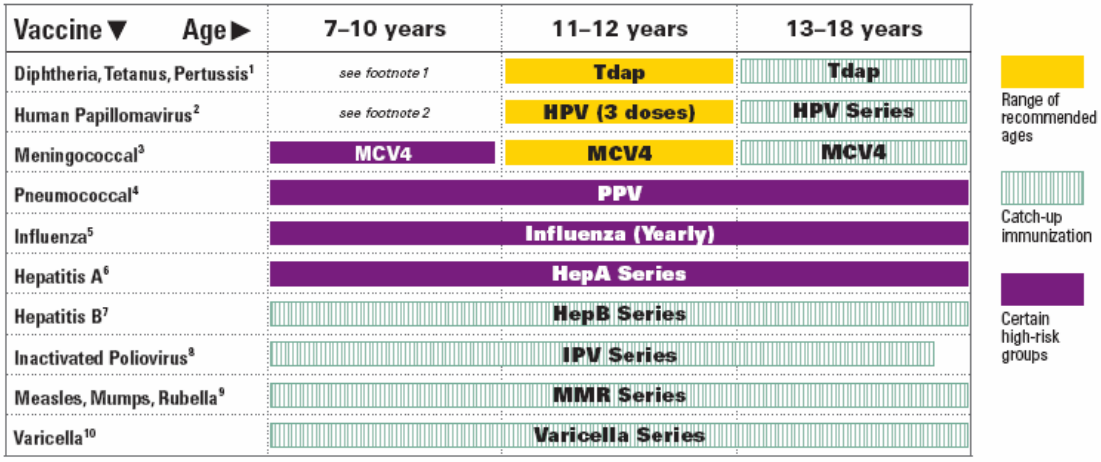
CS103164

Recommended Immunization Schedule for Persons Aged 7–18 Years—UNITED STATES • 2008

For those who fall behind or start late, see the green bars and the catch-up schedule



This schedule indicates the recommended ages for routine administration of currently licensed childhood vaccines, as of December 1, 2007, for children aged 7–18 years. Additional information is available at www.cdc.gov/vaccines/recs/schedules. Any dose not administered at the recommended age should be administered at any subsequent visit, when indicated and feasible. Additional vaccines may be licensed and recommended during the year. Licensed combination vaccines may be used whenever any components of the combination are indicated and other components of the vaccine are not contraindicated and if approved by the Food and Drug Administration for that dose of the series. Providers should consult the respective Advisory Committee on Immunization Practices statement for detailed recommendations, including for **high risk conditions:** http://www.cdc.gov/vaccines/pubs/ACIP-list.htm. Clinically significant adverse events that follow immunization should be reported to the Vaccine Adverse Event Reporting System (VAERS). Guidance about how to obtain and complete a VAERS form is available at www.vaers.hhs.gov or by telephone, 800-822-7967.

1. Tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap). *(Minimum age: 10 years for BOOSTRIX® and 11 years for ADACEL™)*
- Administer at age 11–12 years for those who have completed the recommended childhood DTP/DTaP vaccination series and have not received a tetanus and diphtheria toxoids (Td) booster dose.
- 13–18-year-olds who missed the 11–12 year Tdap or received Td only are encouraged to receive one dose of Tdap 5 years after the last Td/DTaP dose.

2. Human papillomavirus vaccine (HPV). *(Minimum age: 9 years)*
- Administer the first dose of the HPV vaccine series to females at age 11–12 years.
- Administer the second dose 2 months after the first dose and the third dose 6 months after the first dose.
- Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

3. Meningococcal vaccine.
- Administer MCV4 at age 11–12 years and at age 13–18 years if not previously vaccinated. MPSV4 is an acceptable alternative.
- Administer MCV4 to previously unvaccinated college freshmen living in dormitories.
- MCV4 is recommended for children aged 2–10 years with terminal complement deficiencies or anatomic or functional asplenia and certain other high-risk groups.
- Persons who received MPSV4 3 or more years previously and remain at increased risk for meningococcal disease should be vaccinated with MCV4.

4. Pneumococcal polysaccharide vaccine (PPV).
- Administer PPV to certain high-risk groups.

5. Influenza vaccine.
- Administer annually to all close contacts of children aged 0–59 months.
- Administer annually to persons with certain risk factors, health-care workers, and other persons (including household members) in close contact with persons in groups at higher risk.
- Administer 2 doses (separated by 4 weeks or longer) to children younger than 9 years who are receiving influenza vaccine for the first time or who were vaccinated for the first time last season but only received one dose.
- For healthy nonpregnant persons (those who do not have underlying medical conditions that predispose them to influenza complications) ages 2–49 years, either LAIV or TIV may be used.

6. Hepatitis A vaccine (HepA).
- Administer the 2 doses in the series at least 6 months apart.
- HepA is recommended for certain other groups of children, including in areas where vaccination programs target older children.

7. Hepatitis B vaccine (HepB).
- Administer the 3-dose series to those who were not previously vaccinated.
- A 2-dose series of Recombivax HB® is licensed for children aged 11–15 years.

8. Inactivated poliovirus vaccine (IPV).
- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if the third dose was administered at age 4 years or older.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.

9. Measles, mumps, and rubella vaccine (MMR).
- If not previously vaccinated, administer 2 doses of MMR during any visit, with 4 or more weeks between the doses.

10. Varicella vaccine.
- Administer 2 doses of varicella vaccine to persons younger than 13 years of age at least 3 months apart. Do not repeat the second dose if administered 28 or more days following the first dose.
- Administer 2 doses of varicella vaccine to persons aged 13 years or older at least 4 weeks apart.

The Recommended Immunization Schedules for Persons Aged 0–18 Years are approved by the Advisory Committee on Immunization Practices (www.cdc.gov/vaccines/recs/acip), the American Academy of Pediatrics (http://www.aap.org), and the American Academy of Family Physicians (http://www.aafp.org).

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Catch-up Immunization Schedule

UNITED STATES • 2008

for Persons Aged 4 Months–18 Years Who Start Late or Who Are More Than 1 Month Behind

The table below provides catch-up schedules and minimum intervals between doses for children whose vaccinations have been delayed. A vaccine series does not need to be restarted, regardless of the time that has elapsed between doses. Use the section appropriate for the child's age.

Vaccine	Minimum Age for Dose 1	Minimum Interval Between Doses			
		Dose 1 to Dose 2	Dose 2 to Dose 3	Dose 3 to Dose 4	Dose 4 to Dose 5
CATCH-UP SCHEDULE FOR PERSONS AGED 4 MONTHS–6 YEARS					
Hepatitis B[1]	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Rotavirus[2]	6 wks	4 weeks	4 weeks		
Diphtheria, Tetanus, Pertussis[3]	6 wks	4 weeks	4 weeks	6 months	6 months[3]
Haemophilus influenzae type b[4]	6 wks	4 weeks if first dose administered at younger than 12 months of age 8 weeks (as final dose) if first dose administered at age 12-14 months No further doses needed if first dose administered at 15 months of age or older	4 weeks[4] if current age is younger than 12 months 8 weeks (as final dose)[4] if current age is 12 months or older and second dose administered at younger than 15 months of age No further doses needed if previous dose administered at age 15 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Pneumococcal[5]	6 wks	4 weeks if first dose administered at younger than 12 months of age 8 weeks (as final dose) if first dose administered at age 12 months or older or current age 24–59 months No further doses needed for healthy children if first dose administered at age 24 months or older	4 weeks if current age is younger than 12 months 8 weeks (as final dose) if current age is 12 months or older No further doses needed for healthy children if previous dose administered at age 24 months or older	8 weeks (as final dose) This dose only necessary for children aged 12 months–5 years who received 3 doses before age 12 months	
Inactivated Poliovirus[6]	6 wks	4 weeks	4 weeks	4 weeks[6]	
Measles, Mumps, Rubella[7]	12 mos	4 weeks			
Varicella[8]	12 mos	3 months			
Hepatitis A[9]	12 mos	6 months			
CATCH-UP SCHEDULE FOR PERSONS AGED 7–18 YEARS					
Tetanus, Diphtheria/ Tetanus, Diphtheria, Pertussis[10]	7 yrs[10]	4 weeks	4 weeks if first dose administered at younger than 12 months of age 6 months if first dose administered at age 12 months or older	6 months if first dose administered at younger than 12 months of age	
Human Papillomavirus[11]	9 yrs	4 weeks	12 weeks (and 24 weeks after the first dose)		
Hepatitis A[9]	12 mos	6 months			
Hepatitis B[1]	Birth	4 weeks	8 weeks (and 16 weeks after first dose)		
Inactivated Poliovirus[6]	6 wks	4 weeks	4 weeks	4 weeks[6]	
Measles, Mumps, Rubella[7]	12 mos	4 weeks			
Varicella[8]	12 mos	4 weeks if first dose administered at age 13 years or older 3 months if first dose administered at younger than 13 years of age			

1. Hepatitis B vaccine (HepB).
- Administer the 3-dose series to those who were not previously vaccinated.
- A 2-dose series of Recombivax HB® is licensed for children aged 11–15 years.

2. Rotavirus vaccine (Rota).
- Do not start the series later than age 12 weeks.
- Administer the final dose in the series by age 32 weeks.
- Do not administer a dose later than age 32 weeks.
- Data on safety and efficacy outside of these age ranges are insufficient.

3. Diphtheria and tetanus toxoids and acellular pertussis vaccine (DTaP).
- The fifth dose is not necessary if the fourth dose was administered at age 4 years or older.
- DTaP is not indicated for persons aged 7 years or older.

4. *Haemophilus influenzae* type b conjugate vaccine (Hib).
- Vaccine is not generally recommended for children aged 5 years or older.
- If current age is younger than 12 months and the first 2 doses were PRP-OMP (PedvaxHIB® or ComVax® [Merck]), the third (and final) dose should be administered at age 12–15 months and at least 8 weeks after the second dose.
- If first dose was administered at age 7–11 months, administer 2 doses separated by 4 weeks plus a booster at age 12–15 months.

5. Pneumococcal conjugate vaccine (PCV).
- Administer one dose of PCV to all healthy children aged 24–59 months having any incomplete schedule.
- For children with underlying medical conditions, administer 2 doses of PCV at least 8 weeks apart if previously received less than 3 doses, or 1 dose of PCV if previously received 3 doses.

6. Inactivated poliovirus vaccine (IPV).
- For children who received an all-IPV or all-oral poliovirus (OPV) series, a fourth dose is not necessary if third dose was administered at age 4 years or older.
- If both OPV and IPV were administered as part of a series, a total of 4 doses should be administered, regardless of the child's current age.
- IPV is not routinely recommended for persons aged 18 years and older.

7. Measles, mumps, and rubella vaccine (MMR).
- The second dose of MMR is recommended routinely at age 4–6 years but may be administered earlier if desired.
- If not previously vaccinated, administer 2 doses of MMR during any visit with 4 or more weeks between the doses.

8. Varicella vaccine.
- The second dose of varicella vaccine is recommended routinely at age 4–6 years but may be administered earlier if desired.
- Do not repeat the second dose in persons younger than 13 years of age if administered 28 or more days after the first dose.

9. Hepatitis A vaccine (HepA).
- HepA is recommended for certain groups of children, including in areas where vaccination programs target older children. See *MMWR* 2006;55(No. RR-7):1–23.

10. Tetanus and diphtheria toxoids vaccine (Td) and tetanus and diphtheria toxoids and acellular pertussis vaccine (Tdap).
- Tdap should be substituted for a single dose of Td in the primary catch-up series or as a booster if age appropriate; use Td for other doses.
- A 5-year interval from the last Td dose is encouraged when Tdap is used as a booster dose. A booster (fourth) dose is needed if any of the previous doses were administered at younger than 12 months of age. Refer to ACIP recommendations for further information. See *MMWR* 2006;55(No. RR-3).

11. Human papillomavirus vaccine (HPV).
- Administer the HPV vaccine series to females at age 13–18 years if not previously vaccinated.

Information about reporting reactions after immunization is available online at http://www.vaers.hhs.gov or by telephone via the 24-hour national toll-free information line 800-822-7967. Suspected cases of vaccine-preventable diseases should be reported to the state or local health department. Additional information, including precautions and contraindications for immunization, is available from the National Center for Immunization and Respiratory Diseases at http://www.cdc.gov/vaccines or telephone, 800-CDC-INFO (800-232-4636).

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A.7 Required Screening Protocols

The following table lists medical, vision, hearing, and dental screening protocols for infants and children by recipient age. **Refer to the following page for adolescents.**

	Infancy						Early Childhood					Middle Childhood						
Age By	**1 Mo**	**2 Mo**	**4 Mo**	**6 Mo**	**9 Mo**	**12 Mo**	**15 Mo**	**18 Mo**	**24 Mo**	**3 Yr**	**4 Yr**	**5 Yr**	**6 Yr**	**7 Yr**	**8 Yr**	**9 Yr**	**10 Yr**	
Medical Screening [1]	X	X	X	X	X	X	X	X	X	<----------Annually---------->								
Initial/Interval History	X	X	X	X	X	X	X	X	X	<----------Annually---------->								
Measurements																		
Height and Weight	X	X	X	X	X	X	X	X	X	<----------Annually---------->								
Head Circumference	X	X	X	X	X	X	X	X	X									
Body-mass index (BMI) [8] – If clinically indicated									X	X		X	X	X	X	X	X	X
Blood Pressure/Pulse										<----------Annually---------->								
Developmental Assessment	S	S	S	S	S	S	S	S	S	<----------Annually---------->								
Physical Exam/Assessment [2]	X	X	X	X	X	X	X	X	X	<----------Annually---------->								
Procedures																		
Immunization	X	X	X	X		<-------X------>						<----X---->						
Metabolic Screening 9																		
Sickle Cell Screening 9																		
Anemia Screening	X----------					X												
Urine screening[3] (Effective 10/01/2008 urine screens should be performed only when clinically indicated).																		
Lead Screening [4]					X+	**X**	X+	X+	**X**	X+		X+	X+	X+				
Nutritional Assessment	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X	S/X		S/X	<--------Annually-->					
Health Education [5]	X	X	X	X	X	X	X	X	X	X		X	<--------Annually-->					
Vision Screening [6]	S	S	S	S	S	S	S	S	S	O		O	O	O	O	O	O	O
Hearing Screening [6]	S	S	S	S	S	S	S	S	S	S		O	O	O	O	O	O	O
Dental Screening [7]						<----------Annually---------->												
TB Skin Test [8] **(TST)**	The decision to place a TST should be made after completing a risk assessment using A.3.5 and determining the tuberculosis prevalence in the community by contacting the local health officials.																	

Added: (Effective 10/01/2008, urine…when clinically indicated.

Key

X	Required at the visit for this age
X+	Perform blood lead level if unknown
S	Subjective by history and observation
O	Objective by standard testing methods
<----->	Annually
X-------X	One test must be administered during this time frame. Providers have the option of obtaining the lead and Hct or Hgb at nine or twelve months of age.
<---X--->	Range in which a service may be provided, where X indicates the preferred age
1	If a child comes under care for the first time at any point of the schedule, or if any components are not accomplished at the recommended age, the schedule should be brought up to date at the earliest possible time.
2	The physical examination/assessment must include an oral/dental inspection.
3	Urine screening (dipstick) is done if clinically indicated and must be done at 5 years and 11-21 years of age. (Effective 10/01/2008 urine screening performed only when clinically indicated).
4	All children are considered at risk and must be screened for lead poisoning. A blood lead test is required at 12 and 24 months of age. Providers have the option of obtaining the lead and Hct or Hgb at nine or twelve months of age. **X** indicated lead screening is required. X+ indicates a screening blood lead test also is required for any Medicaid-eligible child 36 to 72 months of age who has not previously been screened for lead poisoning.
5	Health education must include anticipatory guidance and interpretive conference. Youth, ages 12 to 20, must receive more intensive health education that addresses physiological, emotional, substance usage and reproductive health issues at each screening visit.
6	These screenings must be performed annually. Patient should be rescreened within 30-45 days if he/she is uncooperative.
7	A child must be referred for an annual complete dental screening beginning at age three to age 21 unless the child is under care. Anticipatory guidance should begin with age one.
8	Please refer to Section A.3.5, Critical Components of Screenings, for detailed information.
9	These laboratory tests **do not** need to be performed again if you have obtainable, verifiable results. Screen for PKU and other disorders prior to discharge or 24 hours after birth, according to state law. A single PKU is adequate when performed at least 24 hours after birth in a well infant or when performed at 6 to 7 days of age in a premature or ill infant. The newborn screening Program tests results satisfies this requirement. For more information, please refer to Newborn Screening Program.

Added: (Effective 10/01/2008, urine…when clinically indicated.)

Adolescent Screening Protocols

For adolescents 11-20 years of age the following are performed annually:

- History
- Height/Weight
- Blood Pressure/Pulse
- Body-mass index (BMI) – BMI should be performed at each visit if clinically indicated. BMI-for-age charts are recommended to assess weight in relation to stature for children ages 2 to 20 years. The weight-for-stature charts are available as an alternative to accommodate children ages 2-5 years who are not evaluated beyond the preschool years. However, all health care providers should consider using the BMI-for-age charts to be consistent with current recommendations. The charts are available on the American Academy of Pediatrics website at http://www.aap.org .
- Developmental Assessment
- Physical Exam

- Urine Screening (Effective 10/01/2008 urine screening is no longer a requirement. Urine screens are done only if clinically indicated

Added: (Effective 10/01/2008, urine…if clinically indicated.)

- Nutritional Assessment
- Health Education
- Vision Screening
- Hearing Screening
- Dental Screening

An anemia screening should be performed once for adolescents 11-20 years of age.

A urine screening should be performed annually for adolescents 11-20 years of age.

Effective 10/01/2008 urine screens no longer a requirement of adolescent EPSDT screenings. Urine screens should only be done when clinically indicated.

Added: (Effective 10/01/2008, urine…when clinically indicated.)

Immunizations are performed for adolescents 11-16 years of age according to AICP guidelines. Refer to Section A.7.4, Recommended Immunization Schedule, for the recommended ages for vaccines.

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Alabama Early Intervention

Child Find Referral Form

1-800-543-3098/VOICE/TDD

En Español: 1-866-450-2838

INFANT/TODDLER INFORMATION

1. SSN#: _____ 2. Date of Birth: _____

3. Last Name: _____ First Name: _____ MI: _____

4. Sex: _____ 5. Ethnic Origin: _____6. Home Language: _____

CHILD RELATION INFORMATION

7. First Name: _____ Last Name: _____ MI:_____

8. Relation Type:_____ **9. Is this Primary relation? Y or N** **10.Is address same as child's? Y or N**

11. Mailing Address:_____

City/State/Zip: _____ 12. County: _____

13. Physical Address:_____

City/State/Zip:_____ 14. County:_____

15. Home Phone: ( ) _____ 16. Alternate Phone: ( )_____Ext #: _____

REFERRAL SOURCE INFORMATION

17. Person making referral: _____ 18. Referral Source: _____

19. County: _____ 20. Phone: ( ) _____21. Fax: ( ) _____

22. Reason for referral: _____

23. How family became aware of Child Find:_____ Additional Information:_____

Refer to Service Coordinator/Caseload ID:_____

Date Mailed/Faxed to Child Find: _____ Sender: _____

Mail to: ADRS/EI, 2129 E. South Blvd., Montgomery, AL 36111 Fax Number: 334-613-3494

REFERRALS NOT ACCEPTED UNLESS ALL BLANKS ARE COMPLETED

(STATE OFFICE USE ONLY)

Processed by: _____ **Official referral/entry date:** _____

REVISED 02/04

Question #5: - Ethnic Origin

1. **Black or African American (not Hispanic) –** A person having origins in any of the Black racial groups of Africa.
2. **White (not Hispanic) –** A person having origins in any of the original peoples of Europe, the Middle East, or North Africa.
3. **American Indian or Alaska Native –** A person having origins in any of the original peoples of North and South America (including Central America) and who maintains tribal affiliation or community attachment.
4. **Asian or Pacific Islander –** A person having origins in any of the original peoples of the Far East, Southeast Asia, the Indian subcontinent, or the Pacific Islands, including, the Philippine Islands, Thailand, and Vietnam. The Pacific Islands include Hawaii, Guam, and Samoa.
5. **Hispanic or Latino –** A person Cuban, Mexican, Puerto Rican, South or Central American, or other Spanish culture or origin, regardless of race.

Question #6 – Child's Home Language

1 – American Sign Language
2 – Spanish
3 – Asian
4 – English
5 – Other

Question #23 – How Family Became Aware of Child Find

1 – Agency
2 – APC Parenting Kit
3 – Child Care
4 – Therapist
5 – Doctor
6 – EI Programs
7 – Web Site
8 – Relative/Friend
9 – High Risk
10 – PA Materials
11 – Media
12 – Healthy Child Care AL
13 – Hospital
14 – SSA
15 – EI in Other State
16 – Parent(Child in EI before)
17 – EI Recipient's Family
18 – Dev. Follow-Up Clinic
19 - Other

Question #12, #14, and #19 – County Code

01	Autauga	24	Dallas	47	Marion
02	Baldwin	25	DeKalb	48	Marshall
03	Barbour	26	Elmore	49	Mobile
04	Bibb	27	Escambia	50	Monroe
05	Blount	28	Etowah	51	Montgomery
06	Bullock	29	Fayette	52	Morgan
07	Butler	30	Franklin	53	Perry
08	Calhoun	31	Geneva	54	Pickens
09	Chambers	32	Greene	55	Pike
10	Cherokee	33	Hale	56	Randolph
11	Chilton	34	Henry	57	Russell
12	Choctaw	35	Houston	58	Saint Clair
13	Clarke	36	Jackson	59	Shelby
14	Clay	37	Jefferson	60	Sumter
15	Cleburne	38	Lamar	61	Talladega
16	Coffee	39	Lauderdale	62	Tallapoosa
17	Colbert	40	Lawrence	63	Tuscaloosa
18	Conecuh	41	Lee	64	Walker
19	Coosa	42	Limestone	65	Washington
20	Covington	43	Lowndes	66	Wilcox
21	Crenshaw	44	Macon	67	Winston
22	Cullman	45	Madison		
23	Dale	46	Marengo		